IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OKLAHOMA

SOJOURN CARE, INC. d/b/a SOJOURN CARE OF TULSA, a Delaware Corporation,	)	
Plaintiff,	)	
v.	)	Case No. 07-CV-375-GKF-PJC
MICHAEL O. LEAVITT, Secretary of United States Department of Health and Human Services,	)	
Defendant.	)	

DECLARATION

I, David Daucher, of lawful age, being first duly sworn, upon oath declare that:

1. I am making the following statements based upon personal knowledge, unless stated otherwise.

2. I am the Chief Executive Officer of Sojourn Care, Inc.

3. Attached as Exhibit A is a true and correct print-out of a download from: http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloades/11OSPICE05.pdf, a webpage on Medicare's website, http://www/cms.hhs.gov, on October 18, 2007.

4. Sojourn Care received its license as a hospice provider in Tulsa, Oklahoma in August 2002. Since that time, Sojourn Care has served approximately 2,000 patients in Tulsa.

5. Attached as Exhibit B are true and correct copies of correspondence received from Medicare concerning Sojourn Care's cap surpluses for fiscal years 2003 and 2004.

6. For fiscal year 2005 (ended October 31, 2005), Sojourn Care served many patients first admitted in fiscal year 2004 and a few patients first admitted in fiscal year 2003. Medicare paid Sojourn Care for these services as rendered in fiscal year 2005. However,

because of the cap regulation which traps cap room in prior years, Sojourn Care received no cap allocation for these patients in fiscal year 2005.

7. Attached as Exhibit C is a true and correct copy of Medicare's correspondence requesting Sojourn' Care's cost report for fiscal year 2005 and Sojourn Care's cost report for fiscal year 2005. The cost report for fiscal year 2005 shows that Sojourn Care took care of a total of 861 Medicare patients for a total of 112,747 Medicare days of service, yielding an average length of stay of 131 days.

I declare under penalty of perjury under the laws of the United States of America and the State of Oklahoma that the foregoing is true and correct and that I executed this declaration on October 25, 2007 in Washington D.C.

David E/Daucher

DAVID DAUCHER

DECLARATION OF DAVID DAUCHER

EXHIBIT A

Medicare Hospice Utilization by State
Calendar Year 2005

	Total Patients	Total Reimbursement	Total Covered Days	Total Covered Hours	Total Covered Procedures	Average Reimbursement Per Patient	Average Days Per Patient
TOTAL	865,916	$7,848,872,435	57,984,391	5,089,661	1,130,055	$9,064	67
ALABAMA	23,641	$304,828,386	2,673,319	120,927	8,537	$12,894	113
ALASKA	358	$2,970,652	20,126	0	110	$8,298	56
ARIZONA	25,447	$281,835,218	1,937,677	19,502	48,732	$11,075	76
ARKANSAS	8,675	$79,995,772	691,623	19,495	6,848	$9,221	80
CALIFORNIA	76,285	$730,201,662	4,706,851	434,490	83,615	$9,572	62
COLORADO	13,243	$111,526,282	767,193	10,336	53,799	$8,422	58
CONNECTICUT	8,117	$65,658,802	327,385	11,238	13,290	$8,089	40
DELAWARE	2,898	$24,609,086	178,243	6,052	297	$8,492	62
DISTRICT OF COLUMBIA	801	$5,645,894	35,047	0	1,164	$7,049	44
FLORIDA	82,934	$883,400,483	5,536,174	2,331,247	316,367	$10,652	67
GEORGIA	24,507	$238,000,015	1,732,831	39,537	50,160	$9,712	71
HAWAII	1,790	$14,809,938	92,304	0	60	$8,274	52
IDAHO	3,649	$32,016,288	260,154	5,888	443	$8,774	71
ILLINOIS	33,044	$258,032,719	1,783,935	308,921	22,259	$7,809	54
INDIANA	19,220	$175,377,880	1,389,136	11,330	29,764	$9,125	72
IOWA	12,250	$84,681,950	707,069	5,971	8,392	$6,913	58
KANSAS	8,720	$72,667,514	587,577	12,690	6,235	$8,333	67
KENTUCKY	11,069	$83,780,377	654,953	19,048	16,688	$7,569	59
LOUISIANA	13,300	$110,063,547	895,979	21,936	10,419	$8,275	67
MAINE	3,144	$24,056,803	182,885	90	424	$7,652	58
MARYLAND	11,444	$76,304,738	553,999	317	9,311	$6,668	48
MASSACHUSETTS	16,345	$137,026,741	905,289	3,874	2,312	$8,383	55
MICHIGAN	32,704	$233,593,730	1,814,627	53,174	33,657	$7,143	55
MINNESOTA	11,840	$98,872,082	743,977	12,463	2,341	$8,351	63
MISSISSIPPI	13,152	$184,481,885	1,603,757	34,398	1,650	$14,027	122
MISSOURI	22,716	$182,726,237	1,570,164	15,144	2,211	$8,044	69
MONTANA	2,463	$16,276,438	132,240	347	551	$6,608	54
NEBRASKA	4,882	$32,281,628	318,676	8,077	379	$6,612	65

NEVADA	6,706	$63,506,597	387,232	2,516	26,627	$9,470	58
NEW HAMPSHIRE	2,924	$22,652,259	144,377	311	1,162	$7,747	49
NEW JERSEY	21,356	$166,219,171	1,097,810	46,544	18,098	$7,783	51
NEW MEXICO	6,761	$76,349,579	685,352	3,211	4,645	$11,293	101
NEW YORK	32,228	$262,905,858	1,630,451	24,329	27,141	$8,158	51
NORTH CAROLINA	25,335	$239,823,510	1,860,643	11,630	45,076	$9,466	73
NORTH DAKOTA	1,687	$12,168,844	100,667	5,952	395	$7,213	60
OHIO	42,018	$341,255,188	2,426,783	416,340	40,988	$8,122	58
OKLAHOMA	19,098	$239,237,900	2,069,943	41,342	4,153	$12,527	108
OREGON	13,834	$102,700,020	813,928	6,206	1,519	$7,424	59
PENNSYLVANIA	43,749	$332,666,945	2,640,709	54,522	58,423	$7,604	60
PUERTO RICO	7,075	$59,090,644	741,237	565	54,896	$8,352	105
RHODE ISLAND	3,711	$29,208,741	183,875	138	1,816	$7,871	50
SOUTH CAROLINA	12,292	$117,314,218	985,810	12,670	4,824	$9,544	80
SOUTH DAKOTA	1,758	$9,813,124	79,495	0	243	$5,582	45
TENNESSEE	15,917	$130,780,100	996,537	27,405	12,879	$8,216	63
TEXAS	62,655	$590,361,249	4,472,922	838,290	63,315	$9,422	71
UTAH	7,844	$89,239,267	684,970	7,098	7,135	$11,377	87
VERMONT	1,173	$7,822,696	61,458	1,600	204	$6,669	52
VIRGIN ISLANDS	84	$850,542	7,919	363	0	$10,126	94
VIRGINIA	16,080	$120,924,829	967,201	8,975	6,122	$7,520	60
WASHINGTON	15,085	$116,202,875	803,574	6,093	6,332	$7,703	53
WEST VIRGINIA	5,143	$41,878,417	340,921	11,966	3,800	$8,143	66
WISCONSIN	15,674	$124,281,936	921,110	54,879	10,234	$7,929	59
WYOMING	790	$5,895,179	76,277	224	13	$7,462	97

EXHIBIT A PAGE 5

DECLARATION OF DAVID DAUCHER

EXHIBIT B

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

September 16, 2004

MAY 17 2005

Ms. Renee Berryman
Sojourn Care of Tulsa
7975 N. Hayden Road
Suite A-108
Scottsdale, AZ 85258-3246

Subject: Notice of Effect of Inpatient Day Limitation and
Hospice Cap Amount
Sojourn Care of Tulsa
Provider Number: 37-1607
Period From: 8-27-02 to 10-31-03

Dear Ms. Berryman:

We have completed our review regarding the hospice limitation on inpatient days under 42CFR 418.302(F). For the cap year 8-27-02 to 10-31-03, the total inpatient days cannot exceed twenty percent of the total hospice care days. Based on this review, your hospice has not exceeded the twenty percent limitation on inpatient days; therefore, no amount is due the Medicare program.

As discussed in the Medicare Regulations, Section 418.309, hospices are subject to a cap on the total Medicare payments made to the agency. The hospice cap amount for the cap year 8-27-02 to 10-31-03 is $18,479.80. We have completed our review of the hospice cap amount for your agency. As a result of this review, Medicare payments to your agency have not exceeded the cap amount; therefore, no amount is due the Medicare program.

If you have any questions concerning the hospice cap amount, please call me at extension 15624.

Sincerely,

Lou Massi

Lou Massi 09-16-04
Reimbursement Consultant
Provider Reimbursement

/rs

cc: Provider File

Sojourn CARE INC.

To: Lou Massi
From: Renee Berryman, Sojourn Care, Inc. #371607
Date: August 17, 2004
Subject: Cap period 8/27/2002 to 9/27/2003

Thank you for sending me the additional information for Hospice Cap. I have reconciled the SE/SW HOSPICE CAP RPT – 9/28/02 thru 9/27/03 report that you faxed to me to our records. You thought that maybe I didn't capture everyone for the cap period; however, your report included those patients that have been counted in a previous cap year by another hospice. Below is my reconciliation. At your request I added 11 for those patients admitted from our certification date of 8/27/2002 to 9/27/2002. I have attached a listing of patients for each line below.

Total from SE/SW HOSPICE CAP RPT 9/28/02 to 9/27/03	**275**
Less: No. of duplicates included in report	-4
Less: No. of patients not in their initial election period	-11
Less: Transfers to Sojourn Care	-7
Less: Transfer out of Sojourn Care	-5
Total Number of Beneficiaries Initially Electing Hospice from 9/28/02 to 9/27/03	248
Add: Elections from 8/27/02 to 9/27/02	11
TOTAL INITIAL ELECTIONS FOR THIS CAP PERIOD	**259**

In summary, our total cap for this period using only the initial elections is $4,833,274 (259 * 18,661). Our total Medicare payments for service dates between 8/27/2002 and 10/31/2003 is $2,912,480 with is well under our cap amount for this year.

7975 N. Hayden Road, Suite A 208 ◆ Scottsdale, Arizona 85258 ◆ phone: 480-905-1346 ◆ fax: 480-905-1352

EXHIBIT B PAGE 8

Hospice Cap Calculation

Provider Name: Sojourn Care, Inc.
Provider Number: 37-1607
CAP Year: 8/27/2002 to 10/31/2003

REVIEW OF MEDICARE INPATIENT DAYS

1. TOTAL HOSPICE CARE DAYS PER THE PS&R	24997	
2. * 20%	x 20%	
3. ALLOWABLE MEDICARE INPATIENT DAYS	4999.400	
4. ACTUAL INPATIENT DAYS PER THE PS&R	441	
**If the total number of inpatient days exeeded the allowable number of days the limitation for your agence is determined as follows:		
A. MEDICARE REIMBURSEMENT FOR INPATIENT SERVICES	$ -	
X THE PERCENTAGE OF MAX ALLOWABLE DAYS (line 3/line 4)	0.00%	-
B. DAYS IN EXCESS OF ALLOWABLE DAYS MULTIPLIED BY THE ROUTINE HOME CARE RATE	0 $ -	$ -
C SUM OF A AND B		$ -
MEDICARE REIMBURSEMENT FOR INPATIENT CARE PER PS&R		
TOTAL AMOUNT DUE THE INTERMEDIARY		$ -

CAP ON OVERAL MEDICARE REIMBURSEMENT

1. MEDICARE BENEFICIARIES ELECTING HOSPICE CARE	259
2. STATUTORY CAP AMOUNT FOR THE CAP YEAR ENDED	$ 18,661.29
3. ALLOWABLE MEDICARE PAYMENTS	$ 4,833,274.11
4. ACTUAL PAYMENTS PER THE PS&R	2,912,480.53
5. PAYMENTS IN EXCESS OF THE CAP AMOUNT	$ -

EXHIBIT B PAGE 9

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

July 21, 2005

Ms. Renee Berryman, CFO 37-1607
Sojourn Care of Tulsa
7975 N. Hayden Road
Suite A-108
Scottsdale, AZ 85258-3246

JUL 26 2005

Subject: Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount for
Sojourn Care of Tulsa
Provider Number: 37-1607
Period From: November 1, 2003 through October 31, 2004

Dear Ms. Berryman:

We have completed our review regarding the hospice limitation on inpatient days under 42CFR 418.302(F). For the above referenced cap year, the total inpatient days cannot exceed twenty percent of the total hospice care days. Based on this review, your hospice has not exceeded the twenty percent limitation on inpatient days; therefore, no amount is due the Medicare program.

As discussed in the Medicare Regulations, Section 418.309, hospices are subject to a cap on the total Medicare payments made to the agency. The hospice cap amount for the above referenced cap year is $19,635.67. We have completed our review of the hospice cap amount for your agency. As a result of this review, Medicare payments to your agency have not exceeded the cap amount; therefore, no amount is due the Medicare program.

If you have any questions concerning the hospice cap amount, please call me at extension 15636.

Sincerely,

Stephanie Josephik CH 7-21-05
Accountant III
Provider Reimbursement

cc: Provider File

HOSPICE CAP CALCULATION

JUL 26 2005

PROVIDER NAME:	Sojourn Care of Tulsa
PROVIDER NUMBER:	37-1607
CAP YEAR:	11/1/2003 To 10/31/2004

REVIEW OF MEDICARE INPATIENT DAYS		
1. TOTAL HOSPICE CARE DAYS PER THE PS&R	56187	
2. * 20%	x 20%	
3. ALLOWABLE MEDICARE INPATIENT DAYS	11237.3	
4. ACTUAL INPATIENT DAYS PER THE PS&R	478	
****DAYS IN EXCESS OF THE ALLOWABLE DAYS**	**0**	
** If the total number of inpatient days exceeded the allowable number of days the limitation for your agency is determined as follows:		
A. MEDICARE REIMBURSEMENT FOR INPATIENT SERVICES	$0.00	
X THE PERCENTAGE OF MAX ALLOWABLE DAYS (line 3/line 4)	0.00%	$0.00
B. DAYS IN EXCESS OF ALLOWABLE DAYS	0	
MULTIPLIED BY THE ROUTINE HOME CARE RATE	$0.00	$0.00
C. SUM OF A AND B		$0.00
MEDICARE REIMBURSEMENT FOR INPATIENT CARE PER PS&R		$0.00
TOTAL AMOUNT DUE THE INTERMEDIARY		**$0.00**

CAP ON OVERALL MEDICARE REIMBURSEMENT		
1. MEDICARE BENEFICIARIES ELECTING HOSPICE CARE		336.0000
2. STATUTORY CAP AMOUNT FOR THE CAP YEAR ENDED		$19,635.67
3. ALLOWABLE MEDICARE PAYMENTS		$6,597,585.12
4. ACTUAL PAYMENTS PER THE PS&R PAID THROUGH	6/30/05	$6,371,985.00
5. PAYMENTS IN EXCESS OF THE CAP AMOUNT		**$0**

RE-QSF-7.5.1 CC-Hospice Cap Excel Spreadsheet 2004
Revision 0, 3/3/05

EXHIBIT B PAGE 11

DECLARATION OF DAVID DAUCHER

EXHIBIT C

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

April 14, 2006

Ms. Renee Berryman, CFO
Sojourn Care of Tulsa
7975 N. Hayden Road
Suite A-108
Scottsdale, AZ 85258-3246

SOJOURN CARE, INC.
APR 17 2006
RECEIVED

RE: MEDICARE COST REPORT DUE: May 31, 2006
FOR: SOJOURN CARE OF TULSA
PROVIDER NUMBER: 37-1607
FISCAL YEAR ENDED: December 31, 2005

Dear Ms. Berryman:

The Medicare cost report for Sojourn Care of Tulsa and any subunits, for the fiscal year ended December 31, 2005 is due on or before May 31, 2006 (Reference: 42 CFR Section 413.24(f)). We have enclosed a checklist and PS&R summary report if available and applicable to your provider type to assist you in completing your cost report. The HCFA form 339 maybe obtained by going to http://www.cms.hhs.gov/manuals/pub152/PUB_15_2.asp.

Effective immediately for all Hospice and End Stage Renal Dialysis (ESRD) providers with a fiscal year ending on or after December 31, 2004:

Hospice and ESRD providers must now submit their cost reports as required under the Medicare Regulations in a standardized electronic format, (ECR file) using a CMS approved vendor system. Although the "hard copy" will be the "official" copy of the cost report during the first year transition period, providers are required to submit both the hard copy cost report along with the electronic file (ECR file) on diskette.

If the cost report is completed manually, it must be on the official CMS worksheets in conjunction with CMS free software. Any computer-generated substitutes for the cost reporting forms must have current CMS approval. This electronic format should be accompanied with a hard copy of the cost report and the two should be filed together.

Please pay close attention to the attached checklist to ensure your cost report is submitted with all of the necessary items. If the items listed in the "Supporting Information – All Providers" sections are not received with the cost report, intermediaries have been instructed to request missing items. Specifically, be sure to include copies of the schedules or working papers for reclassifications, adjustments, related organizations, contracted therapists, and protested items. Please forward your completed cost report and all supporting documentation to the following address. This address is to be used for US Postal Service and courier deliveries.

Palmetto GBA
Provider Reimbursement CA-106
34650 US Highway 19 North, Ste 202 • Palm Harbor, Florida 34684-2156 • (727) 773-9225 • Fax (727) 771-7838

A CMS Contracted Intermediary and Carrier

Revision 0; 04/22/05

EXHIBIT C PAGE 13

Palmetto GBA - Provider Reimbursement
Attn: Cost Report Acceptance – CA-106
34650 US Highway 19 North, Ste 202
Palm Harbor, FL 34684-2156

There are several articles on the Palmetto GBA web site (PalmettoGBA.com) with information on cost report filing. After opening the web site, all hospice providers should make the following selections: Providers / Regional Home Health & Hospice Intermediary (RHHI) / Audit & Reimbursement / Cost Report Filing. All ESRD providers should make the following selections: Providers / Part A Intermediary / South Carolina Part A Intermediary / Audit & Reimbursement / Cost Report Filing.

It is important to file your cost report on or before May 31, 2006. If you are unable to submit your cost report by the due date, you may request in writing a reduced payment suspension rate of 50%, which can remain in affect for up to 60 days. Please note that a request for a reduced payment suspension rate must be submitted prior to the cost report due date. Also, note that all submitted cost reports are subject to a desk review and/or audit by our audit department. Please note that if your cost report is determined unacceptable, you will be notified in writing that your cost report has been rejected, and payments will be suspended if the cost report due date has past. A terminated provider's payments will be immediately suspended at 100% if they fail to file their cost report timely. Upon receiving an acceptable cost report and collecting all overpayments and interest, the withheld payments will be released. If there are other overpayments not on an approved repayment schedule – the withheld payments will be used to collect those overpayments.

If the cost report indicates an amount due the Medicare Program, please submit a check made payable to **MEDICARE FEDERAL HIB** for the full amount and mail the **check** in a separate envelope to the following address:

Medicare Finance (AG-361)
Palmetto GBA, LLC
Post Office Box 100183
3060 Alpine Road
Columbia, SC 29223

If a timely filed cost report indicates an amount due the Medicare Program and the amount due is not submitted, payments will be withheld. In addition, interest accrues unless full payment accompanies the cost report, or the provider agrees in advance to liquidate the overpayment through a reduction in interim payments over the next 30-day period. If the cost report is not filed timely, interest will accrue on the amount due beginning the day after the date the cost report was due.

The interest rate for overpayments determined on or after January 25, 2006 is 11.875%. Interest is charged in 30-day periods. For instance, if your cost report is 32 days late, two 30-day periods of interest will apply.

If you are unable to repay the cost report overpayment, you may submit documentation supporting a request for extended repayment. This documentation must be submitted with or prior to the submission of your cost report in order to avoid withholding of your payments. The required documentation includes, but is not limited to, balance sheets, income statements, cash flow statements, and statements of source and application funds. The first payment of the proposed repayment schedule **must** be included with the documentation. If you need a listing of the required documentation or have questions pertaining to a repayment schedule, please review the information on the Palmetto GBA web site by selecting: Providers / Regional Home Health & Hospice Intermediary (RHHI) / Audit & Reimbursement / Overpayments or call Michael Rockholt at (803) 735-1034, extension 26328.

EXHIBIT C PAGE 14

If you have any questions or need additional information, please contact me at (803) 382-6113.

Sincerely,

Diane A. Green

Diane A. Green
Accounting Technician II, Provider Reimbursement
Palmetto GBA

Enclosures: Filing Checklist
Expansion of Service and/or Business Form
Medicare PS&R Summary Report

EXHIBIT C PAGE 15

COST REPORT FILING CHECKLIST

This checklist is included to assist you in accurately completing and filing your cost report.

Providers Filing Electronic Cost Reports

Note: The electronic cost report (ECR) is required to be filed by hospitals, home health agencies, hospices, end stage renal dialysis (ESRD's), and skilled nursing facilities. Other provider types are not required to file the electronic cost report and the hardcopy of the cost report is the official copy.

- ☑ Diskette submitted must contain:
  - ECR file
  - Print image file of the cost report (except when using CMS free software)
- ☑ Certification page (Worksheet S) as produced from the ECR file with the actual signature of an officer (administrator or chief financial officer)
- ☑ Certification page must include the encryption code of both the ECR file and the print image file
- ☑ Teaching hospitals submit a complete Intern and Resident Information System (IRIS) diskette
- ☑ Completed cost report questionnaire (CMS Form 339) with original signature on certification page and applicable supporting documentation

Providers using the CMS Free Software or Providers Not Required to File an Electronic Cost Reports

- ☑ Must submit a complete and legible hard copy of the cost report on the proper forms
- ☑ Certification page of the cost report with the original signature of an officer (administrator or chief financial officer)
- ☑ Must submit a complete and legible cost report questionnaire (CMS Form 339) with an original signature

Supporting Information – All Providers

- ☑ Documentation required by the cost report questionnaire (CMS Form 339)
- ☑ (please refer to the web site article addressing modifications to the questionnaire)
- ☑ Copy of the working trial balance
- ☑ Copy of the audited financial statements where applicable
- ☑ Supporting documentation for reclassifications, adjustments, related organizations, contracted therapists, and protested items.
- ☑ For teaching hospitals correctly updated graduate medical education (GME) per resident amounts

Conditions Under Which Less Than a Full Cost Report May Be Filed

No Medicare Utilization – Submit a statement on the agency's letterhead, signed by an authorized official, identifying the cost report period. This must state 1) no covered services were furnished during the reporting period, and 2) no claims for Medicare reimbursement will be filed for this reporting period. In addition, submit the signed certification page of the cost report.

Low Medicare Utilization – This is an option if Medicare net reimbursement is less than $100,000. Submit the S series of the cost report and the worksheets that present the balance sheet and statement of revenues and expenses. For HHAs this is the F-series and for SNFs this is the G-series. Also, submit a trial balance for the period.

Electronic cost report filing and submission of the CMS form 339 are not required for No or Low utilization Cost Reports.

EXHIBIT C PAGE 16

EXPANSION OF SERVICES AND/OR BUSINESS

All providers are to answer the following and attach it to the front of their submitted Form HCFA 339:

- Has your facility/business purchased a physician practice or any other entity during the current cost reporting year? _____
- If yes, have you notified your Regional Office and fiscal intermediary? _____
- If yes, has the state agency completed their survey and granted approval that the entity or physician practice purchased is considered provider-based? _____
- If yes, is this included in your cost report as a provider-based entity? _____

EXHIBIT L PAGE 17

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

PROGRAM ID: MD430502 - V35.D
PAID DATES: 01/01/05 THRU 04/04/06
RUN DATE: 04/06/06
PROVIDER FYE: 12/31
PROVIDER NUMBER: 371607

PROVIDER SUMMARY REPORT
HOSPICE - NON-HOSPITAL BASED (MSP-LCC)

SOJOURN CARE OF TULSA

REPORT #: OD44203
REPORT TYPE: 81A

REVENUE CODE	DESCRIPTION	SERVICES FOR PERIOD 01/01/05 - 12/31/05 UNITS	CHARGES	SERVICES FOR PERIOD 00/00/00 - 00/00/00 UNITS	CHARGES	SERVICES FOR PERIOD 00/00/00 - 00/00/00 UNITS	CHARGES	SERVICES FOR PERIOD 00/00/00 - 00/00/00 UNITS	CHARGES
	DISCHARGES	0		0		0		0	
	MEDICARE DAYS	0		0		0		0	
	CLAIMS	2		0		0		0	
*** ANCILLARY CHARGES ***									
0651	HOSPICE/RTN HOME	24	$4,320.00		$.00		$.00		$.00
	TOTAL CHARGES		$4,320.00		$.00		$.00		$.00
	GROSS REIMBURSEMENT		$2,400.00		$.00		$.00		$.00
	CASH DEDUCTIBLE		$.00		$.00		$.00		$.00
	BLOOD DEDUCTIBLE		$.00		$.00		$.00		$.00
	COINSURANCE		$.00		$.00		$.00		$.00
	NET PRIMARY PAYOR PAYMENTS MADE UNDER MSP		$2,087.28		$.00		$.00		$.00
	NET REIMBURSEMENT		$312.72		$.00		$.00		$.00
	INFORMATIONAL ONLY:								
	INTEREST PAYMENTS		$.00		$.00		$.00		$.00
	TOTAL ADJUSTMENTS		$.00		$.00		$.00		$.00

EXHIBIT C PAGE 16

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

PROGRAM ID: MD430502 - V35.D
PAID DATES: 01/01/05 THRU 04/04/06
RUN DATE: 04/06/06
PROVIDER FYE: 12/31
PROVIDER NUMBER: 371607

PROVIDER SUMMARY REPORT
HOSPICE - NON-HOSPITAL BASED

SOJOURN CARE OF TULSA

REPORT #: OD44203
REPORT TYPE: 810

REVENUE CODE	DESCRIPTION	SERVICES FOR PERIOD 01/01/05 - 12/31/05 UNITS	SERVICES FOR PERIOD 01/01/05 - 12/31/05 CHARGES	SERVICES FOR PERIOD 00/00/00 - 00/00/00 UNITS	SERVICES FOR PERIOD 00/00/00 - 00/00/00 CHARGES	SERVICES FOR PERIOD 00/00/00 - 00/00/00 UNITS	SERVICES FOR PERIOD 00/00/00 - 00/00/00 CHARGES	SERVICES FOR PERIOD 00/00/00 - 00/00/00 UNITS	SERVICES FOR PERIOD 00/00/00 - 00/00/00 CHARGES
	DISCHARGES	0		0		0		0	
	MEDICARE DAYS	0		0		0		0	
	CLAIMS	8,695		0		0		0	
*** ANCILLARY CHARGES ***									
0651	HOSPICE/RTN HOME	112,110	$13,326,298.00		$.00		$.00		$.00
0652	HOSPICE/CTNS HOME	879	$25,417.25		$.00		$.00		$.00
0655	HOSPICE/IP RESPITE	209	$26,034.71		$.00		$.00		$.00
0656	HOSPICE/IP NON RESP	371	$198,595.96		$.00		$.00		$.00
0657	HOSPICE/PHYSICIAN S	387	$54,097.23		$.00		$.00		$.00
	TOTAL CHARGES		$13,630,443.15		$.00		$.00		$.00
	GROSS REIMBURSEMENT		$13,605,000.63		$.00		$.00		$.00
	CASH DEDUCTIBLE		$.00		$.00		$.00		$.00
	BLOOD DEDUCTIBLE		$.00		$.00		$.00		$.00
	COINSURANCE		$.00		$.00		$.00		$.00
	NET PRIMARY PAYOR PAYMENTS MADE UNDER MSP		$3,100.00		$.00		$.00		$.00
	NET REIMBURSEMENT		$13,601,900.63		$.00		$.00		$.00
	INFORMATIONAL ONLY:								
	INTEREST PAYMENTS		$97.16		$.00		$.00		$.00
	TOTAL ADJUSTMENTS		$.00		$.00		$.00		$.00

EXHIBIT L PAGE 19

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

PROGRAM ID: MD430506 - V35.D
PAID DATES: 01/01/05 THRU 04/04/06
RUN DATE: 04/06/06
PROVIDER FYE: 1231
PROVIDER: 371607 SOJOURN CARE OF TULSA

PROVIDER SUMMARY REPORT
MSA/BENEFICIARY CENSUS/REV VISITS
HOSPICE - NON-HOSPITAL BASED (MSP-LCC)

PAGE: 5347
REPORT #: OD45300
REPORT TYPE: 81A

COUNT TYPE	SERVICE PERIOD 01/01/05-12/31/05	SERVICE PERIOD	SERVICE PERIOD	SERVICE PERIOD
ALL CBSA BENEFICIARY COUNTS	1.00	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	24	0	0	0
BCSA 8560 BENEFICIARY COUNTS	1.00	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	24	0	0	0

EXHIBIT C PAGE 20

P R O V I D E R S T A T I S T I C A L A N D R E I M B U R S E M E N T S Y S T E M

PROGRAM ID: MD430506 - V35.D
PAID DATES: 01/01/05 THRU 04/04/06
RUN DATE: 04/06/06
PROVIDER FYE: 1231
PROVIDER: 371607 SOJOURN CARE OF TULSA

PROVIDER SUMMARY REPORT
MSA/BENEFICIARY CENSUS/REV VISITS
HOSPICE - NON-HOSPITAL BASED

PAGE: 5348
REPORT #: OD45300
REPORT TYPE: 810

COUNT TYPE	SERVICE PERIOD 01/01/05-12/31/05	SERVICE PERIOD	SERVICE PERIOD	SERVICE PERIOD
ALL CBSA BENEFICIARY COUNTS	838.00	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	112110	0	0	0
REVENUE CNTR 0652 VISIT COUNTS	879	0	0	0
BCSA 37 BENEFICIARY COUNTS	57.68	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	7696	0	0	0
REVENUE CNTR 0652 VISIT COUNTS	68	0	0	0
BCSA 0104 BENEFICIARY COUNTS	7.50	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	953	0	0	0
BCSA 0341 BENEFICIARY COUNTS	117.49	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	18074	0	0	0
BCSA 50104 BENEFICIARY COUNTS	9.61	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	679	0	0	0
REVENUE CNTR 0652 VISIT COUNTS	12	0	0	0
BCSA 50106 BENEFICIARY COUNTS	0.01	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	3	0	0	0
BCSA 50107 BENEFICIARY COUNTS	22.37	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	2203	0	0	0
BCSA 50304 BENEFICIARY COUNTS	0.00	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	0	0	0
BCSA 50341 BENEFICIARY COUNTS	136.46	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	11501	0	0	0
REVENUE CNTR 0652 VISIT COUNTS	78	0	0	0
BCSA 8560 BENEFICIARY COUNTS	487.06	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	71001	0	0	0
REVENUE CNTR 0652 VISIT COUNTS	721	0	0	0

EXHIBIT C PAGE 2

2005 Cost Report Filed.

EXHIBIT C PAGE 22

KPMG'S Electronic Reporting to Compu-Max File Conversion Utility
Transmittal #6 - CMS-1984-99

Electronic File Name: HSTEMP.ECR

Compu-Max File Name: S:\FINANCE\COSTRE~1\2005\CR2005V1

Provider Name: SOJOURN CARE OF TULSA

Provider Nunber: 37-1607

Fiscal Year Beginning: 2005/001 (Julian Date Format)

Fiscal Year Ending: 2005/365 (Julian Date Format)

Conversion Date and Time: 04/21/2006 09:38:53

ECR Fingerprint:

Software Vendor: A01 KPMG LLP - COMPU-MAX MICRO

ECR File Creation Date: 2006/111 (Julian Date Format)

ECR Programming Specification Date: 2004/366 (Julian Date Format)

EXHIBIT C PAGE 23

PROVIDER NO. 37-1607 SOJOURN CARE OF TULSA
PERIOD FROM 01/01/2005 TO 12/31/2005

KPMG COMPU-MAX MICRO SYSTEM VERSION: 2005.03
IN LIEU OF FORM CMS-1984-99 (4/99) Page 1 4/21/2006 9:44:24 AM

HOSPICE COST AND DATA REPORT

WORKSHEET S

INTERMEDIARY USE ONLY

[ ] AUDITED DATE RECEIVED ____________ [ ] INITIAL [ ] RE-OPENED
[ ] DESK REVIEWED INTERMEDIARY NO. ____________ [ ] FINAL

CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY SOJOURN CARE OF TULSA 37-1607 (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORT PERIOD BEGINNING 01/01/2005 AND ENDING 12/31/2005, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE REPORT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 4/21/2006 9:44:23 AM
3UtQbBq1JLVW:55uKgXcPcYaYULWP0
vDnqV0bnRv.7tlt7eKKCtYhaYFZjjZ
lvPs0bXAVK0ZnyoT

PI Encryption: 4/21/2006 9:44:24 AM
Ju6AgAXKBjxeYt0F2GIdAXBrFMLdp0
L:yC:0feaKLwlLOs04zZyITlzbc:9q
9AL61Jau0.0hHIEB

(SIGNED) [signature]
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

CFO
TITLE

4-21-06
DATE

480-905-1346
PHONE NUMBER

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0758. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED AT 176 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING DATA RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850 AND TO THE OFFICE OF INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

EXHIBIT C PAGE 24

WORKSHEET S-1

HOSPICE IDENTIFICATION DATA

PART I

1	NAME: SOJOURN CARE OF TULSA	ADDRESS: 9910 EAST 42ND STREET SOUTH CITY: TULSA STATE: OK ZIP CODE: 74146		1
2	COUNTY WHERE THE HOSPICE IS LOCATED	TULSA		2
3	HOSPICE BEGAN OPERATION (MM/DD/YYYY)		DATE 03/13/2002	3
4	CERTIFICATON DATE (MM/DD/YYYY)	DATE CERTIFIED TITLE XVIII 08/27/2002	DATE CERTIFIED TITLE XIX / /	4
5	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2005 TO: 12/31/2005		5
6	PROVIDER IDENTIFICATION NUMBER		37-1607	6
7	TYPE OF CONTROL		5	7

PART II

ENROLLMENT DAYS	TITLE XVIII UNDUPLICATED MEDICARE DAYS 1	TITLE XIX UNDUPLICATED MEDICAID DAYS 2	TITLE XVIII UNDUPLICATED SKILLED NURSING FACILITY DAYS 3	TITLE XIX UNDUPLICATED NURSING FACILITY DAYS 4	OTHER UNDUPLICATED 5	TOTAL UNDUPLICATED DAYS 6	
8 CONTINUOUS HOME CARE	57				7	64	8
9 ROUTINE HOME CARE	112110				9142	121252	9
10 INPATIENT RESPITE CARE	209					209	10
11 GENERAL INPATIENT CARE	371				9	380	11
12 TOTAL HOSPICE DAYS	112747				9158	121905	12

PART III

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SKILLED NURS FAC 3	TITLE XIX NURS FAC 4	OTHER 5	TOTAL 6	
13 NUMBER OF PATIENTS RECEIVING HOSPICE CARE	861				100	961	13
14 TOTAL UNDUP CONT CARE HOURS BILLABLE TO MEDICARE	903					903	14
15 AVERAGE LENGTH OF STAY	130.95				91.58	126.85	15
16 UNDUPLICATED CENSUS COUNT	861					861	16
17 IF THE HOSPICE COMPONENTIZED (OR FRAGMENTED) ITS ADMINISTRATIVE AND GENERAL SERVICE COSTS, INDICATE WHETHER OPTION ONE OR TWO IS BEING UTILIZED. (SEE PRM-II, SECTION 3820)(ENTER '1' FOR OPTION ONE AND '2' FOR OPTION TWO.)							17
18 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB.15-1, CHAPTER 10? IF YES, ENTER THE CHAIN HOME OFFICE PROVIDER NUMBER IN COLUMN 2.					N		18

EXHIBIT C PAGE 25

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES 1	EMPLOYEE BENEFITS 2	TRANS-PORTATION 3	CONTRACTED SERVICES 4	OTHER 5	TOTAL 6	
		GENERAL SERVICE COST CENTERS							
1	0100	Cap Rel Costs - Bldg & Fixt					217924	217924	1
2	0200	Cap Rel Costs - Mvble Equip					130	130	2
3	0300	Plant Operation and Maintenance					7505	7505	3
5	0500	Volunteer Services	56710	15276				71986	5
6	0600	Administrative & General	2101357	390260			3228217	5799834	6
		INPATIENT CARE SERVICE							
10	1000	Inpatient - General Care					205019	205019	10
11	1100	Inpatient - Respite Care					86428	86428	11
		VISITING SERVICES							
15	1500	Physicians Services				232379		232379	15
16	1600	Nursing Care	2619727	705653	215865	12934		3554179	16
17	1700	Physical Therapy					10424	10424	17
20	2000	Medical Social Services	431945	116349	39011			587305	20
21	2100	Spiritual Counseling	345590	93089	42288			480967	21
23	2300	COUNSELING - OTHER	25107	6763				31870	23
24	2400	Home Health Aide and Homemaker	1011820	272545	252186	8622		1545173	24
25	2500	Other Visiting Services			10363			10363	25
		OTHER HOSPICE SERVICE COSTS							
30	3000	Drugs,Biological,Infusion Therapy					827976	827976	30
31	3100	Durable Medical Equipment/Oxygen					561531	561531	31
32	3200	Patient Transportation					23073	23073	32
34	3400	Labs and Diagnostics					35958	35958	34
35	3500	Med Supplies Charged to Patient					298321	298321	35
36	3600	Outpatient Services (Inc E/R Dept					44731	44731	36
37	3700	Radiation Therapy					2160	2160	37
38	3800	Chemotherapy					13023	13023	38
		HOSPICE NONREIMBURSABLE SERV							
50	5000	Bereavement Program Costs							50
51	5100	Volunteer Program Cost							51
100		TOTAL	6672256	1599935	567713	253935	5562420	14656259	100

EXHIBIT C PAGE 21

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

	COST CENTER DESCRIPTIONS	RECLASSI-FICATIONS 7	SUBTOTAL 8	ADJUSTMENTS 9	TOTAL 10	
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs - Bldg & Fixt		217924		217924	1
2	Cap Rel Costs - Mvble Equip		130	190824	190954	2
3	Plant Operation And Maintenance		7505		7505	3
5	Volunteer Services		71986		71986	5
6	Administrative & General		5799834		5799834	6
	INPATIENT CARE SERVICE					
10	Inpatient - General Care		205019		205019	10
11	Inpatient - Respite Care		86428		86428	11
	VISITING SERVICES					
15	Physicians Services		232379		232379	15
16	Nursing Care		3554179		3554179	16
17	Physical Therapy		10424		10424	17
20	Medical Social Services		587305		587305	20
21	Spiritual Counseling		480967		480967	21
23	COUNSELING - OTHER		31870		31870	23
24	Home Health Aide and Homemaker		1545173		1545173	24
25	Other Visiting Services		18363		18363	25
	OTHER HOSPICE SERVICE COSTS					
30	Drugs,Biological,Infusion Therapy		827976		827976	30
31	Durable Medical Equipment/Oxygen		561531		561531	31
32	Patient Transportation		23073		23073	32
34	Labs and Diagnostics		35958		35958	34
35	Med Supplies Charged to Patient		298321		298321	35
36	Outpatient Services (Inc E/R Dept		44731		44731	36
37	Radiation Therapy		2160		2160	37
38	Chemotherapy		13023		13023	38
	HOSPICE NONREIMBURSABLE SERV					
50	Bereavement Program Costs					50
51	Volunteer Program Cost					51
100	TOTAL		14656259	190824	14847083	100

EXHIBIT C PAGE 21

COMPENSATION ANALYSIS
SALARIES AND WAGES

WORKSHEET A-1

	COST CENTER DESCRIPTIONS	ADMINIS-TRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERA-PISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTERS										1
1	Cap Rel Costs - Bldg & Fixt										2
2	Cap Rel Costs - Mvble Equip										3
3	Plant Operation and Maintena								56710	56710	5
5	Volunteer Services								1668673	2181357	6
6	Administrative & General	258274	254410								
	INPATIENT CARE SERVICE										10
10	Inpatient - General Care										11
11	Inpatient - Respite Care										
	VISITING SERVICES										15
15	Physicians Services									2619727	16
16	Nursing Care				701520	1918207					17
17	Physical Therapy									431945	20
20	Medical Social Services			431945					345590	345590	21
21	Spiritual Counseling								25107	25107	23
23	COUNSELING - OTHER										24
24	Home Health Aide and Homemak							1011820		1011820	25
25	Other Visiting Services										
	OTHER HOSPICE SERVICE COSTS										30
30	Drugs,Biological,Infusion Th										31
31	Durable Medical Equipment/Ox										32
32	Patient Transportation										34
34	Labs and Diagnostics										35
35	Med Supplies Charged to Pati										36
36	Outpatient Services (Inc E/R										37
37	Radiation Therapy										38
38	Chemotherapy										
	HOSPICE NONREIMBURSABLE SERV										50
50	Bereavement Program Costs										51
51	Volunteer Program Cost										100
100	TOTAL	258274	254410	431945	701520	1918207		1011820	2096080	6672256	

EXHIBIT C PAGE 28

COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED) WORKSHEET A-2

	COST CENTER DESCRIPTIONS	ADMINIS-TRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERA-PISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTERS										
1	Cap Rel Costs - Bldg & Fixt										1
2	Cap Rel Costs - Mvble Equip										2
3	Plant Operation and Maintena										3
5	Volunteer Services								15276	15276	5
6	Administrative & General	25494	29462						335304	390260	6
	INPATIENT CARE SERVICE										
10	Inpatient - General Care										10
11	Inpatient - Respite Care										11
	VISITING SERVICES										
15	Physicians Services										15
16	Nursing Care				188962	516691				705653	16
17	Physical Therapy										17
20	Medical Social Services			116349						116349	20
21	Spiritual Counseling								93089	93089	21
23	COUNSELING - OTHER								6763	6763	23
24	Home Health Aide and Homemak							272545		272545	24
25	Other Visiting Services										25
	OTHER HOSPICE SERVICE COSTS										
30	Drugs,Biological,Infusion Th										30
31	Durable Medical Equipment/Ox										31
32	Patient Transportation										32
34	Labs and Diagnostics										34
35	Med Supplies Charged to Pati										35
36	Outpatient Services (Inc E/R										36
37	Radiation Therapy										37
38	Chemotherapy										38
	HOSPICE NONREIMBURSABLE SERV										
50	Bereavement Program Costs										50
51	Volunteer Program Cost										51
100	TOTAL	25494	29462	116349	188962	516691		272545	450432	1599935	100

EXHIBIT C PAGE 29

COMPENSATION ANALYSIS
CONTRACTED SERVICES / PURCHASED SERVICES

WORKSHEET A-3

	COST CENTER DESCRIPTIONS	ADMINIS-TRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER-VISORS 4	NURSES 5	TOTAL THERA-PISTS 6	AIDES 7	ALL OTHER 8	TOTAL 9	
	GENERAL SERVICE COST CENTERS										
1	Cap Rel Costs - Bldg & Fixt										1
2	Cap Rel Costs - Mvble Equip										2
3	Plant Operation and Maintena										3
5	Volunteer Services										5
6	Administrative & General										6
	INPATIENT CARE SERVICE										
10	Inpatient - General Care										10
11	Inpatient - Respite Care										11
	VISITING SERVICES										
15	Physicians Services		232379							232379	15
16	Nursing Care					12934				12934	16
17	Physical Therapy										17
20	Medical Social Services										20
21	Spiritual Counseling										21
23	COUNSELING - OTHER										23
24	Home Health Aide and Homemak							8622		8622	24
25	Other Visiting Services										25
	OTHER HOSPICE SERVICE COSTS										
30	Drugs,Biological,Infusion Th										30
31	Durable Medical Equipment/Ox										31
32	Patient Transportation										32
34	Labs and Diagnostics										34
35	Med Supplies Charged to Pati										35
36	Outpatient Services (Inc E/R										36
37	Radiation Therapy										37
38	Chemotherapy										38
	HOSPICE NONREIMBURSABLE SERV										
50	Bereavement Program Costs										50
51	Volunteer Program Cost										51
100	TOTAL		232379			12934		8622		253935	100

EXHIBIT C PAGE 30

RECLASSIFICATIONS

WORKSHEET A-6
PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE NO.	SALARY AMOUNT	NON-SAL AMOUNT
		1	2	3	4	5
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36	TOTAL RECLASSIFICATIONS					

EXHIBIT C PAGE 31

WORKSHEET A-6
PAGE 1

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE			
			COST CENTER	LINE NO.	SALARY AMOUNT	NON-SAL AMOUNT
		1	6	7	8	9
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36	TOTAL RECLASSIFICATIONS					

EXHIBIT C PAGE 32

WORKSHEET A-7

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATIONS 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	
1	LAND							1
2	LAND IMPROVEMENTS							2
3	BUILDINGS AND FIXTURES							3
4	BUILDING IMPROVEMENTS							4
5	FIXED EQUIPMENT	216736	287039		287039		503775	5
6	MOVABLE EQUIPMENT	301103	299852		299852		600955	6
7	SUBTOTAL	517839	586891		586891		1104730	7
8	RECONCILING ITEMS	119379	190824		190824		310203	8
9	TOTAL	398460	396067		396067		794527	9

EXHIBIT C PAGE 33

WORKSHEET A-8

ADJUSTMENTS TO EXPENSES

	DESCRIPTION	BASIS FOR ADJUSTMENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	
1	Investment income on restricted funds					1
2	Telephone services (pay stations excluded)					2
3	Adj resulting from related organization transactions and home office costs	FROM WKS A-8-1				3
4	Revenue - Employee meals, Guests					4
5	Income from interest, etc. charges or penalty charges					5
6	Bad Debts Included on Trial Balance					6
7	Patient Personal Purchases					7
8	Miscellaneous Adjustments					8
9	Depreciation - buildings and fixtures			Cap Rel Costs - Bldg & Fixt	1	9
10	Depreciation - movable equipment		190824	Cap Rel Costs - Mvble Equip	2	10
11	TOTAL		190824			11

EXHIBIT C PAGE 34

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND/OR HOME OFFICES

WORKSHEET A-8-1

B. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS, AND/OR RELATED ORGANIZATION:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT ALLOWABLE IN COST	AMOUNT	NET ADJUSTMENTS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS						5

C. INTERRELATIONSHIP OF PROVIDER TO RELATED ORGANIZATION(S):

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED ON PART C OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL, REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT WILL BE CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

		-------- RELATED ORGANIZATION(S) AND/OR HOME OFFICE --------					
	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
D. DIRECTOR, OFFICER, ADMINISTRATOR, OR OTHER KEY PERSON OF PROVIDER, OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR OTHER KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
F. DIRECTOR, OFFICER, ADMINISTRATOR, OR OTHER KEY PERSON OF RELATED ORGANIZATION, OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
G. OTHER (FINANCIAL OR NONFINANCIAL) SPECIFY:

EXHIBIT C PAGE 35

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION 0	CAPITAL BLDGS & FIXTURES 1	CAPITAL MOVABLE EQUIPMENT 2	PLANT OPER. & MAINT 3	TRANS-PORTAT-ION 4	VOLUNTEER SERVICE COORDI. 5	SUBTOTAL 6A	ADMINIS-TRATIVE & GENERAL 6	
	GENERAL SERVICE COST CENTERS									
1	Cap Rel Costs - Bldg & Fixt	217924	217924							1
2	Cap Rel Costs - Mvble Equip	190954		190954						2
3	Plant Operation and Maintenance	7505			7505					3
4	Transportation - Staff									4
5	Volunteer Services	71986					71986			5
6	Administrative & General	5799834	34194	29962	1178		71986	5937154	5937154	6
	INPATIENT CARE SERVICE									
10	Inpatient - General Care	205019						205019	136615	10
11	Inpatient - Respite Care	86428						86428	57592	11
	VISITING SERVICES									
15	Physicians Services	232379						232379	154846	15
16	Nursing Care	3554179	66943	58657	2304			3682083	2453562	16
17	Physical Therapy	10424						10424	6946	17
18	Occupational Therapy									18
19	Speech / Language Pathology									19
20	Medical Social Services	587305	28655	25109	987			642056	427836	20
21	Spiritual Counseling	480967	28655	25109	987			535718	356977	21
22	Dietary Counseling									22
23	COUNSELING - OTHER	31870						31870	21237	23
24	Home Health Aide and Homemaker	1545173	28655	25109	987			1599924	1066114	24
25	Other Visiting Services	18363						18363	12236	25
	OTHER HOSPICE SERVICE COSTS									
30	Drugs,Biological,Infusion Thera	827976						827976	551724	30
31	Durable Medical Equipment/Oxyge	561531						561531	374170	31
32	Patient Transportation	23073						23073	15375	32
33	Imaging Services									33
34	Labs and Diagnostics	35958						35958	23961	34
35	Med Supplies Charged to Patient	298321	7224	6330	249			312124	207985	35
36	Outpatient Services (Inc E/R De	44731						44731	29807	36
37	Radiation Therapy	2160						2160	1439	37
38	Chemotherapy	13023						13023	8678	38
39	Other Hospice Service Cost Cent									39
	HOSPICE NONREIMBURSABLE SERV									
50	Bereavement Program Costs		9632	8440	332			18404	12264	50
51	Volunteer Program Cost		13966	12238	481			26685	17782	51
52	Fundraising									52
53	Other Nonreimburs Costs Centers									53
100	TOTAL	14847083	217924	190954	7505		71986	14847083	5937154	100

EXHIBIT C PAGE 36

WORKSHEET B

COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTIONS	TOTAL
		7
	GENERAL SERVICE COST CENTERS	
1	Cap Rel Costs - Bldg & Fixt	
2	Cap Rel Costs - Mvble Equip	
3	Plant Operation and Maintenance	
4	Transportation - Staff	
5	Volunteer Services	
6	Administrative & General	
	INPATIENT CARE SERVICE	
10	Inpatient - General Care	341634
11	Inpatient - Respite Care	144020
	VISITING SERVICES	
15	Physicians Services	387225
16	Nursing Care	6135645
17	Physical Therapy	17370
18	Occupational Therapy	
19	Speech / Language Pathology	
20	Medical Social Services	1069892
21	Spiritual Counseling	892695
22	Dietary Counseling	
23	COUNSELING - OTHER	53107
24	Home Health Aide and Homemaker	2666038
25	Other Visiting Services	30599
	OTHER HOSPICE SERVICE COSTS	
30	Drugs,Biological,Infusion Thera	1379700
31	Durable Medical Equipment/Oxyge	935709
32	Patient Transportation	38448
33	Imaging Services	
34	Labs and Diagnostics	59919
35	Med Supplies Charged to Patient	520109
36	Outpatient Services (Inc E/R De	74538
37	Radiation Therapy	3599
38	Chemotherapy	21701
39	Other Hospice Service Cost Cent	
	HOSPICE NONREIMBURSABLE SERV	
50	Bereavement Program Costs	30668
51	Volunteer Program Cost	44467
52	Fundraising	
53	Other Nonreimburs Costs Centers	
100	TOTAL	14847083

EXHIBIT C PAGE 31

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL BLDGS & FIXTURES SQUARE FEET 1	CAPITAL MOVABLE EQUIPMENT DOLLAR VALUE 2	PLANT OPER. & MAINT SQUARE FEET 3	TRANS-PORTAT-ION MILEAGE 4	VOLUNTEER SERVICE COORDI. HOURS OF SERVICE 5	RECONCIL-IATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	
	GENERAL SERVICE COST CENTERS								1
1	Cap Rel Costs - Bldg & Fixt	22625							2
2	Cap Rel Costs - Mvble Equip		22625						3
3	Plant Operation and Maintenance			22625					4
4	Transportation - Staff					6601			5
5	Volunteer Services					6601	-5937154	8909929	6
6	Administrative & General	3550	3550	3550					
	INPATIENT CARE SERVICE							205019	10
10	Inpatient - General Care							86428	11
11	Inpatient - Respite Care								
	VISITING SERVICES							232379	15
15	Physicians Services							3682083	16
16	Nursing Care	6950	6950	6950				10424	17
17	Physical Therapy								18
18	Occupational Therapy								19
19	Speech / Language Pathology							642056	20
20	Medical Social Services	2975	2975	2975				535718	21
21	Spiritual Counseling	2975	2975	2975					22
22	Dietary Counseling							31870	23
23	COUNSELING - OTHER							1599924	24
24	Home Health Aids and Homemaker	2975	2975	2975				18363	25
25	Other Visiting Services								
	OTHER HOSPICE SERVICE COSTS							827976	30
30	Drugs,Biological,Infusion Thera							561531	31
31	Durable Medical Equipment/Oxyge							23073	32
32	Patient Transportation								33
33	Imaging Services							35958	34
34	Labs and Diagnostics							312124	35
35	Med Supplies Charged to Patient	750	750	750				44731	36
36	Outpatient Services (Inc E/R De							2160	37
37	Radiation Therapy							13023	38
38	Chemotherapy								39
39	Other Hospice Service Cost Cent								
	HOSPICE NONREIMBURSABLE SERV							18404	50
50	Bereavement Program Costs	1000	1000	1000				26685	51
51	Volunteer Program Cost	1450	1450	1450					52
52	Fundraising								53
53	Other Nonreimburs Costs Centers							5937154	100
100	COST TO BE ALLOCATED	217924	180954	7505		71986			101
101	UNIT COST MULTIPLIER	9.632000	8.439956	0.331713		10.905317		0.666353	101
101	UNIT COST MULTIPLIER								

EXHIBIT C PAGE 38

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTIONS

	GENERAL SERVICE COST CENTERS	1
1	Cap Rel Costs - Bldg & Fixt	2
2	Cap Rel Costs - Mvble Equip	3
3	Plant Operation and Maintenance	4
4	Transportation - Staff	5
5	Volunteer Services	6
6	Administrative & General	
	INPATIENT CARE SERVICE	10
10	Inpatient - General Care	11
11	Inpatient - Respite Care	
	VISITING SERVICES	15
15	Physicians Services	16
16	Nursing Care	17
17	Physical Therapy	18
18	Occupational Therapy	19
19	Speech / Language Pathology	20
20	Medical Social Services	21
21	Spiritual Counseling	22
22	Dietary Counseling	23
23	COUNSELING - OTHER	24
24	Home Health Aide and Homemaker	25
25	Other Visiting Services	
	OTHER HOSPICE SERVICE COSTS	30
30	Drugs,Biological,Infusion Thera	31
31	Durable Medical Equipment/Oxyge	32
32	Patient Transportation	33
33	Imaging Services	34
34	Labs and Diagnostics	35
35	Med Supplies Charged to Patient	36
36	Outpatient Services (Inc E/R De	37
37	Radiation Therapy	38
38	Chemotherapy	39
39	Other Hospice Service Cost Cent	
	HOSPICE NONREIMBURSABLE SERV	50
50	Bereavement Program Costs	51
51	Volunteer Program Cost	52
52	Fundraising	53
53	Other Nonreimburs Costs Centers	100
100	COST TO BE ALLOCATED	101
101	UNIT COST MULTIPLIER	101
101	UNIT COST MULTIPLIER	

EXHIBIT C PAGE 39

CALCULATION OF PER DIEM COST WORKSHEET D

	COMPUTATION OF PER DIEM COST	TITLE XVIII 1	TITLE XIX 2	OTHER 3	TOTAL 4	
1	TOTAL COST				14047083	1
2	TOTAL UNDUPLICATED DAYS				121905	2
3	AVERAGE COST PER DIEM				121.79	3
4	UNDUPLICATED MEDICARE DAYS	112747				4
5	AVERAGE MEDICARE COST	13731457				5
6	UNDUPLICATED MEDICAID DAYS					6
7	AVERAGE MEDICAID COST					7
8	UNDUPLICATED SNF DAYS					8
9	AVERAGE SNF COST					9
10	UNDUPLICATED NF DAYS					10
11	AVERAGE NF COST					11
12	OTHER UNDUPLICATED DAYS			9158		12
13	AVERAGE COST FOR OTHER DAYS			1115353		13

EXHIBIT C PAGE 40

WORKSHEET G

BALANCE SHEET

	ASSETS (OMIT CENTS)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT ASSETS					
1	Cash on hand and in banks	289106				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	1755666				4
5	Other receivables					5
6	Less: allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses	209933				8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (Sum of lines 1-10)	2254705				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Less: Accumulated depreciation					14
15	Buildings					15
16	Less: Accumulated depreciation					16
17	Leasehold improvements					17
18	Less: Accumulated amortization					18
19	Fixed equipment	503776				19
20	Less: Accumulated depreciation	-80484				20
21	Automobiles and trucks					21
22	Less: Accumulated depreciation					22
23	Major movable equipment	622483				23
24	Less: Accumulated depreciation	-226158				24
25	Minor equipment nondepreciable					25
26	Other fixed assets	52377				26
27	TOTAL FIXED ASSETS (Sum of lines 12-26)	871994				27
	OTHER ASSETS					
28	Investments					28
29	Deposits on leases	38893				29
30	Due from owners/officers					30
31	Other assets	143877				31
32	TOTAL OTHER ASSETS (Sum of lines 28-31)	182770				32
33	TOTAL ASSETS (Sum of lines 11, 27 and 32)	3309469				33

EXHIBIT C PAGE 41

WORKSHEET G

BALANCE SHEET (CONTINUED)

	LIABILITIES AND FUND BALANCE (OMIT CENTS)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT LIABILITIES					
34	Accounts payable	355561				34
35	Salaries, wages & fees payable	361987				35
36	Payroll taxes payable					36
37	Notes & loans payable (Short term)					37
38	Deferred income					38
39	Accelerated payments					39
40	Due to other funds					40
41	Other current liabilities	2254698				41
42	TOTAL CURRENT LIABILITIES (sum of lines 34-41)	2972246				42
	LONG-TERM LIABILITIES					43
43	Mortgage payable					44
44	Notes payable	189719				45
45	Unsecured loans					46A
46A	Loans from owners prior to 7/1/66	400000				46B
46B	Loans from owners on or after 7/1/66					47
47	Other long term liabilities					48
48						49
49	TOTAL LONG TERM LIABILITIES (Sum of lines 43-48)	589719				50
50	TOTAL LIABILITIES (Sum of lines 42 and 49)	3561965				
	CAPITAL ACCOUNTS					51
51	General fund balance	-252496				52
52	Specific purpose fund					53
53	Donor created-endowment fund balance-restricted					54
54	Donor created-endowment fund balance-unrestrictd					55
55	Governing body created-endowment fund balance					56
56	Plant fund balance-invested in plant					57
57	Plant fund balance-reserve for plant improvement, replacement and expansion					58
58	TOTAL FUND BALANCES (Sum of lines 51-57)	-252496				59
59	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 50 and 58)	3309469				

EXHIBIT C PAGE 42

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	Fund balances at beginning of period					1
2	Net income (loss) (From Wkst G-2 line 16)	-905913				2
3	Total (Sum of line 1 and line 2)	-905913				3
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECI					4
5						5
6						6
7						7
8						8
9						9
10	Total Additions (Sum of lines 4-9)					10
11	Subtotal (Line 3 plus line 10)	-905913				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECI					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (Sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet	-905913				19

EXHIBIT C PAGE 43

STATEMENT OF PATIENT REVENUE AND NET INCOME WORKSHEET G-2

PART I - PATIENT REVENUES

	GENERAL INPATIENT AND HOME CARE SERVICE LOCATION	TOTAL	
1	SNF based		1
2	NF based		2
3	Home care	13946506	3
4	Other (see instructions)		4
5	State Medicaid room & board		5
6	Total general inpatient revenues (Sum of lines 1,2,3 and 4)	13946506	6

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col 6, Line 100)		14656259	1
2	DEPRECIATION	190824		2
3	LOSS ON DISPOSAL OF ASSET	5336		3
4				4
5				5
6				6
7				7
8	Total Additions (Sum of lines 2-7)	196160		8
9	Deduct (Specify)			9
10				10
11				11
12				12
13				13
14	Total Deductions (Sum of lines 9-13)			14
15	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)		14852419	15
16	Net Income (or Loss) for the period (line 6 minus line 15)		-905913	16

EXHIBIT C PAGE 44

37-1007

EXPANSION OF SERVICES AND/OR BUSINESS

All providers are to answer the following and attach it to the front of their submitted Form HCFA 339:

- Has your facility/business purchased a physician practice or any other entity during the current cost reporting year? NO
- If yes, have you notified your Regional Office and fiscal intermediary? _____
- If yes, has the state agency completed their survey and granted approval that the entity or physician practice purchased is considered provider-based? _____
- If yes, is this included in your cost report as a provider-based entity? _____

EXHIBIT L PAGE 45

Sojourn Care, Inc.
Trial Balance
As of December 31, 2005

	Debit	Credit
Cash	289,105.88	
Accounts Receivable	1,822,835.50	
Allowance for Doubful Accounts		76,260.75
Notes Receivable	9,091.61	
Prepaid Expenses	209,932.63	
Deposits	38,892.63	
Furniture and Fixtures	503,775.71	
Computer Hardware & Office Equipment	493,042.55	
Computer Software	107,911.84	
Leasehold Improvements	55,937.36	
Accumulated Depreciation/Amortization		310,202.62
Copyright	21,528.97	
Deferred Tax Asset	143,877.00	
Accounts Payable		355,560.56
Accrued Expenses		2,472,807.78
Deferred Tax Liability		143,877.00
Note Payable Shareholder		400,000.00
Wells Fargo Loan		40,000.24
Note Payable - Concert		149,718.90
Common Stock		4,297.61
Series A Convertable Preferred		400.00
Additional Paid in Capital		1,747,921.41
Retained earnings	1,099,203.57	
		13,946,505.73
Revenues	4,490,898.38	
Patient Care Labor	1,239,796.05	
Patient Care Employee Taxes & Benefits	21,555.94	
Contract Patient Care Staff	567,713.52	
Patient Care Travel	205,016.68	
Room and Board - GIP	86,427.51	
Room and Board - Respite	785,266.50	
Pharmacy	561,531.18	
Durable Medical Equipment	298,320.65	
Medical Supplies	42,709.06	
Infusion Services	2,159.97	
Radiation Therapy	13,023.38	
Chemotherapy	17,796.42	
Diagnostic Services	18,160.28	
Laboratory Services	10,423.50	
Rehabilitation Therapy	23,073.49	
Patient Transportation	44,730.56	
Other Outpatient Services	2,181,357.72	
G&A Salaries	390,259.88	
G&A Employee Taxes & Benefits	232,378.50	
Contract Labor G&A	113,912.22	
Employement Cost	44,294.36	
Systems Cost	177,813.18	
G&A Travel Expenses	213,441.82	
Entertainment & Promotion	55,863.03	
Insurance	246,646.79	
Professional Fees	210,635.18	
General Office Expenses	225,428.75	
Office Space	150,294.87	
Telephone	5,705.00	
Business Tax	67,561.31	
Interest Expense		7,500.65
Interest Income	34,850.00	
Bad Debt	1,800,000.00	
Cap Allowance	52,603.62	
Bonus	5,335.90	
Gain/Loss - Asset Disposal	192,928.50	
Depreciation & Amortization		
TOTAL	$ 19,655,053.25	$ 19,655,053.25

EXHIBIT L PAGE 46

OMB NO. 0938-0301

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE (You MUST USE Instructions For Completing This Form Located In PRM-II, §§1100ff.)

Provider Name: SOJOURN CARE OF TULSA

Provider Number: 37-1607

Filed with Form CMS-

Period: From 1/1/2005

(Other Specify) 1984-99

To 12/31/2005

Additional Providers handled under this submission.

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying information prepared by SOJOURN CARE OF TULSA 37-1607 (Provider name(s) and Number(s))

For the cost report period beginning 1/1/2005 and ending 12/31/2005, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signed) _____ Officer or Administrator of Provider(s)

Date 5/1/2006 Title CFO

Name and Telephone Number of Person to Contact for More Information

Renee Berryman 480-905-1346

NOTE: 42 CFR 413.20 and instructions contained in the PRM-1 require that the provider maintain adequate financial and statistical data necessary for the intermediary to use for a proper determination of costs payable under the program. Providers are, therefore, required to maintain and have available for audit all records necessary to verify the amounts and allowability of costs and equity capital included in the filed cost report. Failure to have such records available for review by fiscal intermediaries acting under the authority of the Secretary of the Department of Health and Human Services will render the amount claimed in the cost report unallowable.

A. Provider Organization and Operation

1. The provider has:
   a. Changed ownership? If "yes", submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership. No
   b. Terminated participation. If "yes", list date of termination, and reason (Voluntary/Involuntary). No

2. There have been significant changes in management personnel during the cost reporting period. If "yes", attach list of names and positions. No

3. The provider's organizational chart has changed. If "yes", submit copy and date of change. No

4. The provider, members of the board of directors, officers, medical staff or management personnel are associated with or involved in business transactions with the following:
   a. Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship. No
   b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.). If "yes" to question 4a and/or 4b, attach a list of the individuals, the organizations involved, and description of the transactions. No

5. The provider's Articles of Incorporation and/or Corporate By-Laws or partnership agreement have changed. If "yes", submit copy and date of change as well as a summary of expenses incurred (e.g., Legal and Accounting). No

B. Financial Data and Reports

1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are: No
   a. Audited; No
   b. Compiled; and _____
   c. Reviewed. _____

NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements.

2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation. No

3. The cost report was prepared by the provider's independent accountant or consultant. If "yes", list the preparers: No

EXHIBIT C PAGE 48

Name _____
Address _____
City _____
State _____
Zip _____

C. Capital Related Cost

1. Assets have been relifed for Medicare purposes. If "yes", attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register. No

NOTE: For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, under the capital - PPS consistency rule (42 CFR 412.302 (d)), PPS hospitals are precluded from relifing old capital.

2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense. If "yes", attach copy of Appraisal Report and Appraisal Summary by class of asset. No

3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period. Yes
If "yes", submit a listing of these new leases and/or amendments to existing leases that have the following information:

- o A new lease or lease renewal;
- o Parties to the lease;
- o Period covered by the lease;
- o Description of the asset being leased; and
- o Annual charge by the lessor.

NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.

4. There have been new capitalized leases entered into during the current cost reporting period. If "yes", attach a list of the individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions. No

5. Assets which were subject to §2314 of DEFRA were acquired during the period. If "yes", supply a computation of the basis. No

6. Provider's capitalization policy changed during cost reporting period. If "yes", submit copy. No

7. Obligated capital has been placed into use during the cost reporting period. If "yes", attach schedule listing each project, the cost of these projects and the date placed into service for patient care. No

8. Provider's capital assets have been utilized for personal use. If "yes", submit detail of items No

which are not reimbursed by the employee or not reported to the IRS as an element of the employee's compensation.

D. Interest Expense

1. New loan, mortgage agreements or letters of credit were entered into during the cost reporting period. If "yes", state the purpose and submit copies of debt documents and amortization schedules. Yes

2. The provider has a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. If "yes", submit a detailed analysis of the funded depreciation account for the cost report period. (See CMS PRM-1, §226.4.) No

3. Provider replaced existing debt prior to its scheduled maturity with new debt. If "yes", submit support for new debt and calculation of allowable cost. (See §233.3 for description of allowable cost.) No

4. Provider recalled debt before scheduled maturity without issuance of new debt. If "yes", submit detail of debt cancellation costs. (See §215 for description and treatment of debt cancellation costs.) No

E. Insurance

1. Provider has changed from an insurance program to self-insurance, changed funding arrangements, or significantly changed the deductible and copayment relationships. If "yes", submit a listing of appropriate insurance policies, agreements or contracts which reflect these changed arrangements. No

NOTE: Providers are required to submit copies of the insurance policies, or significant extracts, upon request from the intermediary.

F. Deferred Compensation and Pension

1. A new plan has been instituted. If "yes", submit a copy of the plan and trustee agreement. N/A

2. The existing deferred compensation plans are funded. N/A

3. There has been a change to the existing deferred compensation or pension plan. If "yes", submit addendum. N/A

4. The liability for payments to the Pension Plan is liquidated within the time frame established in §2142.6. If "no", attach explanation including date liquidated and amount involved. N/A

5. All payments were supported by applicable actuarial reports. N/A

Note: Providers are required to submit copies of the actuarial reports upon request of the intermediary.

EXHIBIT C PAGE 50

G. Approved Educational Activities

1. Costs were claimed for Nursing School and Allied Health Programs. If "yes", attach list of the programs and annotate for each whether the provider is the legal operator of the program. N/A

2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs. If "yes", submit copies. N/A

3. Provider has claimed Intern-Resident costs on the current cost report. If "yes", submit the current year Intern-Resident Information System (IRIS) on diskette. N/A

4. Provider has initiated an Intern-Resident program in the current year or obtained a renewal of an existing program. If "yes", submit certification/program approval. N/A

5. Graduate Medical Education costs have been directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program, on Worksheet A, Form CMS-2552. If "yes", submit appropriate workpapers indicating to which cost centers assigned and the amounts. N/A

H. Nonpaid Workers

There are new agreements with the organization of nonpaid workers and/or changes to existing agreements. If "yes", submit copies. No

I. Purchased Services

1. Changes or new agreements have occurred in management and administrative services furnished through contractual arrangements with suppliers of services. If "yes", attach a list of positions filled and services purchased, vendor, and cost of services acquired. No

NOTE: Providers are required to submit copies of new contracts or changes, upon request from intermediary.

2. Changes or new agreements have occurred in patient care services furnished through contractual arrangements with suppliers of services. If "yes", submit copies of changes or contracts, or where there are no written agreements, attach description. No

NOTE: Hospitals are only required to submit such information where the cost of the individual's services exceed $25,000 per year.

3. The requirements of §2135.2 were applied pertaining to competitive bidding. If "no", attach explanation. N/A

4. Contract services are reported on Worksheet S-3, Part II, line 4. N/A

If yes, submit a schedule showing the total direct patient care related contract labor, hours and calculated rate for each invoice paid during the year for the direct patient care related contract labor reported on Worksheet S-3, Part II, line 4.

EXHIBIT C PAGE 51

Contracted labor will include any wage related costs. The contracted amounts for the top four management personnel (CEO, CFO, COO and Nursing Administrator) are not required to be reported by individuals. The total aggregate wage and hours will be reported for these management contracts. Other contracts or contracts for other management personnel should NOT be reported as they are not allowed in the computation of the wage index.

J. Provider-Based Physicians

1. Services are furnished at the provider facility under an arrangement with provider-based physicians. If "yes", submit completed provider-based physician questionnaire (Exhibits 2 through 4A). N/A

2. The provider has entered into new agreements or amended existing agreements with provider-based physicians during this cost reporting period. N/A
If "yes", submit copies of new agreements or amendments to existing agreements and assignment authorizations.

K. Home Office Costs

1. The provider is part of a chain organization. If "yes", give full name and address of the home office: No

Name _____
Address _____
City _____
State _____
Zip _____
Designated Intermediary: _____

2. A home office cost statement has been prepared by the home office. N/A
If "yes", submit a schedule displaying the entire chain's direct, functional and pooled cost as provided to the designated home office intermediary as part of the home office cost statement.

3. The fiscal year end of the home office is different from that of the provider. If "yes", indicate the fiscal year end of the home office. N/A

FYE _____

NOTE: Where the year ends of the provider and home office are not the same (nonconcurrent year ends), the summary listing, as described in number 2 above, will be necessary to support the provider's cost report.

4. Describe the operation of the intercompany accounts. Include in this description the types of costs included from these intercompany accounts and their location on the cost report.
(Provide informative attachments not shown on Worksheet A-8-1).

5. Actual expense amounts are transferred by the home office to the provider components on an interim basis. (Provide informative attachments if not shown on Worksheet A-8-1.)

6. The provider renders services to:

Other chain components. N/A
The home office. N/A

EXHIBIT L PAGE 52

If "yes", to either of the above, provide informative attachments.

7. Home Office or Related Organization personnel cost are reported on Worksheet S-3, Part II, Line 5. N/A

If yes, submit a schedule displaying the wages, wage related costs, and hours allocated to the individual chain components as provided to the designated home office intermediary to support the amount reported on Worksheet S-3, Part II, line 5

L. Bad Debts

1. The provider seeks Medicare reimbursement for bad debts. If "yes", complete Exhibit 5 or submit internal schedules duplicating documentation required on Exhibit 5 to support bad debts claimed. (see instructions) N/A

2. The provider's bad debt collection policy changed during the cost reporting period. If "yes", submit copy. N/A

3. The provider waives patient deductibles and/or copayments. If yes, insure that they are not included on Exhibit 5. N/A

M. Bed Complement

The provider's total available beds have changed from prior cost reporting period. If "yes", provide an analysis of available beds and explain any changes during the cost reporting period. N/A

N. PS&R Data

Refer to the instructions regarding required documentation and attachments.

1. The cost report was prepared using the PS&R only?

a) Part A (including subproviders, SNF, etc.)? N/A

b) Part B (inpatient and outpatient). N/A

If yes, attach a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

2. The cost report was prepared using the PS&R for totals and the provider records for allocation.

a) Part A (including subproviders, SNF, etc). Yes

b) Part B (inpatient and outpatient). N/A

If yes, include a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

If the PS&R is used for the allocation of ASC, Radiology, Other Diagnostic, and All Other Part B, explain how the total charges are detailed to the various PS&R Medicare outpatient types. Include workpapers supporting the allocation of charges into the various cost centers. If internal records are used for either the type of service breakdown or the charge allocation, the source of this information must be included in the documentation.

EXHIBIT C PAGE 53

3. Provider records only were used to complete the cost report?

a) Part A (including subproviders, SNF, etc.). No

b) Part B (inpatient and outpatient). N/A

If yes, attach detailed documentation of the system used to support the data reported on the cost report. If the detail documentation was previously supplied, submit only necessary updated documentation. The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components, ASC payment group rates, Radiology and Other Diagnostic prevailing rates and other claims PRICING information.

- Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.

- Reconciliation of remittance totals to the provider consolidated log totals.

Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material.

Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&R data? No

Part A:

a) If Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. No

Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.

b) Correction of other PS&R information? No

c) Late charges? No

d) Other (describe)? No

Part B (inpatient and outpatient)

a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. No

Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.

b) Correction of other PS&R information? No

c) Late charges? No

d) Other (describe)? No

Attach documentation which provides an audit trail from the PS&R to the cost report. The documentation should include the details of the PS&R, reclassifications, adjustments, and groupings necessary to trace to the cost center totals and in addition, for outpatient services, there should be an audit trail from the PS&R to the amounts shown on the cost report for outpatient charges by ASC, radiology, other diagnostic and all other service categories including standard overhead amounts and prevailing charges.

EXHIBIT L PAGE 54

O. Owners/Management Personnel Compensation

Complete Exhibit 6 (per instructions), for the following:

a. Owners,
b. Management,
c. Relatives of Owners.

P. Wage Related Costs

1. Complete EXHIBIT 7, Part I. (Per instructions) Part III must be completed to reconcile any differences between any fringe benefit cost reported on Worksheet A, Column 2, using Medicare principles and the corresponding wage related costs reported under GAAP for purposes of the wage index computation.

2. The individual wage related cost exceeds one percent of total adjusted salaries after removing excluded salaries. (Salaries reported on Worksheet S-3, Part II, line 3, Col. 3.) N/A

3. Additional wage related costs were provided that meet ALL of the following tests:

   a. The cost is not listed on Part I of EXHIBIT 7. N/A

   b. If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test in question 2 above. N/A

   c. The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS. N/A

   d. The individual wage related cost is not included in salaries reported on the S-3, Part II, line 3, Col. 3. N/A

   e. The wage related cost is not being furnished for the convenience of the employer. N/A

EXHIBIT L PAGE 55

-+-

Attachment for Section C, Question 3

Sojourn Care (Leasee) and KWIRP-Tulsa Associates, L.P. (Lessor)
Valley Ridge Partners Amendment for additional office space
Beg Date 8/1/05 to end date 10/31/11
Annual charge 142,223
New Lease: Drumright Industrial Authority
7/1/05 to 6/30/10
Annual charge 6,000

EXHIBIT L PAGE 56

Attachment for Section D, Question 1

Loan: Concert Business Group
Amount: $76,899.98
Purpose: Furniture purchase

EXHIBIT C PAGE 51

Loan Calculator Results

Loan summary

Monthly payment	$6,761
Loan amount	$76,900.00
Interest rate	10.00%
Term	12

Payment schedule

#	Payment	Principal	Interest	Loan balance
1	$6,761	$6,120	$641	$70,780
2	$6,761	$6,171	$590	$64,609
3	$6,761	$6,222	$538	$58,387
4	$6,761	$6,274	$487	$52,113
5	$6,761	$6,326	$434	$45,786
6	$6,761	$6,379	$382	$39,407
7	$6,761	$6,432	$328	$32,975
8	$6,761	$6,486	$275	$26,489
9	$6,761	$6,540	$221	$19,949
10	$6,761	$6,594	$166	$13,354
11	$6,761	$6,649	$111	$6,705
12	$6,761	$6,705	$56	$0

Provider Name: SOJOURN CARE OF TULSA
Provider Number: 37-1607
FYE: 12/31/2005

PROVIDERS OWNER'S / MANAGEMENT PERSONNEL COMPENSATION EXHIBIT

A separate exhibit must be completed and signed by each owner and any relatives of the owner(s), employed by the provider as well as all management personnel. (Management personnel are limited to the top 10 compensated individuals.) Please read instructions in Section O before completing this form.

CMS considers the compensation information to be confidential, and therefore, qualifying for exemption from disclosure under the Freedom of Information Act, and specifically under 5 U.S.C. §552(b)(4). The compensation information also qualifies for exemption from disclosure under 5 U.S.C. §552(b)(6) which covers "personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." An individual's compensation is a personal matter, and its release would be an invasion of privacy. Accordingly, CMS will not release, or make available to the public, compensation information collected.

1. Name of individual [redacted]
   Title CHIEF EXECUTIVE OFFICER

   Is the individual a (an):

Owner	Yes
Manager	Yes
Employee related to owner	
If related, indicate association to owner.	

2. Amount of compensation claimed:

Salary	$254,409.95
Fringe Benefits	
Pension	
Health Insurance	$14,605.00
Life Insurance	$4,388.00
Dental	$1,200.00
Personal use of business assets	
Other (Specify)	
Total benefits	$20,193.00
Total Compensation (should be the same amount reported on the cost report)	$274,602.95
Payroll Related Taxes	$9,269.00
Number of Hours Worked	>2080

3. Is the employee employed in any other organization? No

EXHIBIT L PAGE 59

Is this organization related to the provider? _____

If yes, complete the following:

Name of Organization _____
Percent of Ownership _____
Title _____
Average # of hours worked per week _____

Annual Compensation received:
Salary _____
Benefits _____
Total $0.00

(If associated with multiple organizations, complete the attached supplemental schedule.)

4. Furnish the following information describing the employee's functional responsibilities (fiscal, patient care, public relations, etc.) for the provider.

A. Is the employee responsible for the fiscal affairs of the provider? Yes

If so, Average hours per week 60
Responsibility level 3. Equally shares duties
Description of Duties: CHIEF EXECUTIVE OFFICER

B. Is the employee responsible for Patient Care? No

If so, Average hours per week _____
Responsibility level _____
Description of Duties: _____

C. Is the employee responsible for Public Relations at the provider? Yes

If so, Average hours per week 5
Responsibility level 3. Equally shares duties
Description of Duties: CHIEF EXECUTIVE OFFICER

D. Other (Describe duties and number of hours):

5. Educational Background

EXHIBIT C PAGE 60

A. Does the employee have an Undergraduate Degree? Yes

If so,

College attended BROWN UNIVERSITY
Graduation date 1974
Degree attained AB

B. Does the employee have a Graduate Degree? Yes

If so,

Graduate School UNIVERSITY OF PENNSYLVANIA-WHARTON GRADUTATE SCHOOL
Graduation date 1976
Degree attained MBA

C. Does the employee have any other formal educational training? No

Other (Describe) _____

6. Does the employee have Administrative/Supervisory experience? Yes

If so,
List experience in an Administrative or Supervisory capacity.

Type of Experiance	Number of Years
HOSPICE - CEO	4
HOSPICE - CFO	2
HOSPITAL - CFO	1
RETAIL - PRESIDENT	3
CONSUMER GOODS - VP/CFO	16

7. Submit the following items with this exhibit:

A) Copy of Job Description
B) Copy of W-2 Form

Certification

This is to certify that I acknowledge the information contained herein and appended, which will be used to determine a reasonable allowance for compensation, is correct to the best of my knowledge and belief. Further, I understand (1) such disclosure will be used in arriving at monies due to or from this provider of covered services to Medicare beneficiaries, and (2) that anyone who misrepresents or falsifies this essential information may upon conviction be subject to fine and/or imprisonment under Federal Law.

[redacted] 4/24/2006

Signature of Individual Date

EXHIBIT C PAGE 61

Provider Name: SOJOURN CARE OF TULSA
Provider Number: 37-1607
FYE: 12/31/2005

PROVIDERS OWNER'S / MANAGEMENT PERSONNEL COMPENSATION EXHIBIT

A separate exhibit must be completed and signed by each owner and any relatives of the owner(s), employed by the provider as well as all management personnel. (Management personnel are limited to the top 10 compensated individuals.) Please read instructions in Section O before completing this form.

CMS considers the compensation information to be confidential, and therefore, qualifying for exemption from disclosure under the Freedom of Information Act, and specifically under 5 U.S.C. §552(b)(4). The compensation information also qualifies for exemption from disclosure under 5 U.S.C. §552(b)(6) which covers "personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." An individual's compensation is a personal matter, and its release would be an invasion of privacy. Accordingly, CMS will not release, or make available to the public, compensation information collected.

1. Name of individual [redacted]
   Title PRESIDENT & CHIEF OPERATING OFFICER

Is the individual a (an):

Owner	Yes
Manager	Yes
Employee related to owner	No
If related, indicate association to owner.	

2. Amount of compensation claimed:

Salary	$258,274.00
Fringe Benefits	
Pension	
Health Insurance	$14,969.00
Life Insurance	
Dental	$1,200.00
Personal use of business assets	
Other (Specify)	
Total benefits	$16,169.00
Total Compensation (should be the same amount reported on the cost report)	$274,443.00
Payroll Related Taxes	$9,325.00
Number of Hours Worked	>2080

3. Is the employee employed in any other organization? No

EXHIBIT C PAGE 62

Is this organization related to the provider? _____

If yes, complete the following:

Name of Organization _____
Percent of Ownership _____
Title _____
Average # of hours worked per week _____

Annual Compensation received:
Salary _____
Benefits _____
Total $0.00

(If associated with multiple organizations, complete the attached supplemental schedule.)

4. Furnish the following information describing the employee's functional responsibilities (fiscal, patient care, public relations, etc.) for the provider.

A. Is the employee responsible for the fiscal affairs of the provider? Yes

If so, Average hours per week 60
Responsibility level 3. Equally shares duties
Description of Duties: CHIEF OPERATING OFFICER

B. Is the employee responsible for Patient Care? Yes

If so, Average hours per week >40
Responsibility level 2. Primary person but shares duties
Description of Duties: PROGRAM ADMINISTRATOR & COMPLIANCE

C. Is the employee responsible for Public Relations at the provider? Yes

If so, Average hours per week 10
Responsibility level 2. Primary person but shares duties
Description of Duties: _____

D. Other (Describe duties and number of hours):

5. Educational Background

EXHIBIT C PAGE 63

A. Does the employee have an Undergraduate Degree? Yes

If so,

College attended WAYNE STATE UNIVERSITY
Graduation date 1973
Degree attained BA

B. Does the employee have a Graduate Degree? Yes

If so,

Graduate School MICHIGAN STATE UNIVERSITY
Graduation date 1989
Degree attained MBA

C. Does the employee have any other formal educational training? No

Other (Describe) _____

6. Does the employee have Administrative/Supervisory experience? Yes

If so,
List experience in an Administrative or Supervisory capacity.

Type of Experiance	Number of Years
HOSPICE - PRESIDENT	4
HOSPICE - COO	6
PRACTICE MGMT COO	2
HOSPICE COO	8
HOSPITAL ASSOC. ADMIN	10

7. Submit the following items with this exhibit:

A) Copy of Job Description
B) Copy of W-2 Form

Certification

This is to certify that I acknowledge the information contained herein and appended, which will be used to determine a reasonable allowance for compensation, is correct to the best of my knowledge and belief. Further, I understand (1) such disclosure will be used in arriving at monies due to or from this provider of covered services to Medicare beneficiaries, and (2) that anyone who misrepresents or falsifies this essential information may upon conviction be subject to fine and/or imprisonment under Federal Law.

[redacted] 4/24/06

Signature of Individual Date

EXHIBIT L PAGE 64

Provider Name: SOJOURN CARE OF TULSA
Provider Number: 37-1607
FYE: 12/31/2005

PROVIDERS OWNER'S / MANAGEMENT PERSONNEL COMPENSATION EXHIBIT

A separate exhibit must be completed and signed by each owner and any relatives of the owner(s), employed by the provider as well as all management personnel. (Management personnel are limited to the top 10 compensated individuals.) Please read instructions in Section O before completing this form.

CMS considers the compensation information to be confidential, and therefore, qualifying for exemption from disclosure under the Freedom of Information Act, and specifically under 5 U.S.C. §552(b)(4). The compensation information also qualifies for exemption from disclosure under 5 U.S.C. §552(b)(6) which covers "personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." An individual's compensation is a personal matter, and its release would be an invasion of privacy. Accordingly, CMS will not release, or make available to the public, compensation information collected.

1. Name of individual [redacted]
   Title CHIEF FINANCIAL OFFICER

   Is the individual a (an):

Owner	
Manager	Yes
Employee related to owner	No
If related, indicate association to owner.	

2. Amount of compensation claimed:

Salary	$136,601.00
Fringe Benefits	
Pension	
Health Insurance	$6,750.00
Life Insurance	
Dental	$780.00
Personal use of business assets	
Other (Specify)	
Total benefits	$7,530.00
Total Compensation (should be the same amount reported on the cost report)	$144,131.00
Payroll Related Taxes	$7,561.00
Number of Hours Worked	>2080

3. Is the employee employed in any other organization? No

EXHIBIT C PAGE 65

Is this organization related to the provider? _____

If yes, complete the following:

Name of Organization _____
Percent of Ownership _____
Title _____
Average # of hours worked per week _____

Annual Compensation received:
Salary _____
Benefits _____
Total $0.00

(If associated with multiple organizations, complete the attached supplemental schedule.)

4. Furnish the following information describing the employee's functional responsibilities (fiscal, patient care, public relations, etc.) for the provider.

A. Is the employee responsible for the fiscal affairs of the provider? Yes

If so, Average hours per week 60
Responsibility level 3. Equally shares duties
Description of Duties: FINANCIAL DUTIES

B. Is the employee responsible for Patient Care? No

If so, Average hours per week _____
Responsibility level _____
Description of Duties: _____

C. Is the employee responsible for Public Relations at the provider? No

If so, Average hours per week _____
Responsibility level _____
Description of Duties: _____

D. Other (Describe duties and number of hours):

5. Educational Background

A. Does the employee have an Undergraduate Degree? Yes

If so,

College attended UNIVERSITY OF NORTH TEXAS
Graduation date 1990
Degree attained BA & BS

B. Does the employee have a Graduate Degree? No

If so,

Graduate School _____
Graduation date _____
Degree attained _____

C. Does the employee have any other formal educational training? Yes

Other (Describe) CPA

6. Does the employee have Administrative/Supervisory experience? Yes

If so,
List experience in an Administrative or Supervisory capacity.

Type of Experiance	Number of Years
DIRECTOR OF FINANCE	4
CONTROLLER	4
AUDIT MANAGER	3
CFO	4

7. Submit the following items with this exhibit:

A) Copy of Job Description
B) Copy of W-2 Form

Certification

This is to certify that I acknowledge the information contained herein and appended, which will be used to determine a reasonable allowance for compensation, is correct to the best of my knowledge and belief. Further, I understand (1) such disclosure will be used in arriving at monies due to or from this provider of covered services to Medicare beneficiaries, and (2) that anyone who misrepresents or falsifies this essential information may upon conviction be subject to fine and/or imprisonment under Federal Law.

[redacted] 4-20-06
Signature of Individual Date

EXHIBIT C PAGE 67

Safe, accurate, FAST! Use IRS e-file. Visit the IRS Website at www.irs.gov.

Employee Reference Copy

W-2 Wage and Tax Statement **2005**

OMB No. 1545-0008

Copy C for employee's records

a Control number	Dept.	Corp.	Employer use only
100005 49/H&Y	001010		A 24

c Employer's name, address, and ZIP code

SOJOURN CARE, INC
7975 N HAYDEN #A-208
SCOTTSDALE AZ 85258

Batch #01053

e/f Employee's name, address, and ZIP code

[redacted]

b Employer's FED ID number	d Employee's SSA number
01-0651003	[redacted]

1 Wages, tips, other comp.	2 Federal income tax withheld
121430.93	20173.92
3 Social security wages	4 Social security tax withheld
90000.00	5580.00
5 Medicare wages and tips	6 Medicare tax withheld
128260.93	1859.78
7 Social security tips	8 Allocated tips
9 Advance EIC payment	10 Dependent care benefits 4000.10
11 Nonqualified plans	12a See instructions for box 12 C 39.52
14 Other	12b D 6830.00
	12c
	12d
	13 Stat emp. [ ] Ret. plan [X] 3rd party sick pay

15 State	Employer's state ID no.	16 State wages, tips, etc.
AZ	01-0651003	121430.93
17 State income tax		18 Local wages, tips, etc.
3833.18		
19 Local income tax		20 Locality name

2005 W-2 and EARNINGS SUMMARY

This blue Earnings Summary section is included with your W-2 to help describe portions in more detail. The reverse side includes general information that you may also find helpful.

1. The following information reflects your final 2005 pay stub plus any adjustments submitted by your employer.

Gross Pay	136601.47	Social Security Tax Withheld Box 4 of W-2	5580.00	AZ State Income Tax Box 17 of W-2 SUI/SDI Box 14 of W-2	3833.18
Fed. Income Tax Withheld Box 2 of W-2	20173.92	Medicare Tax Withheld Box 6 of W-2	1859.78		

2. Your Gross Pay was adjusted as follows to produce your W-2 Statement.

	Wages, Tips, other Compensation Box 1 of W-2	Social Security Wages Box 3 of W-2	Medicare Wages Box 5 of W-2	AZ. State Wages, Tips, Etc. Box 16 of W-2
Gross Pay	136,601.47	136,601.47	136,601.47	136,601.47
Plus GTL (C-Box 12)	39.52	39.52	39.52	39.52
Less 401(k) (D-Box 12)	6,830.00	N/A	N/A	6,830.00
Less Medical FSA	999.96	999.96	999.96	999.96
Less Dependent FSA/DCB	4,000.10	4,000.10	4,000.10	4,000.10
Less Other Cafe 125	3,380.00	3,380.00	3,380.00	3,380.00
Wages Over Limit	N/A	38,260.93	N/A	N/A
Reported W-2 Wages	**121,430.93**	**90,000.00**	**128,260.93**	**121,430.93**

3. Employee W-4 Profile. To change your Employee W-4 Profile Information, file a new W-4 with your payroll dept.

[redacted]

Social Security Number: [redacted]
Taxable Marital Status:
Exemptions/Allowances:
FEDERAL: 2
STATE: Tax is 19 % of Federal

Federal Filing Copy

W-2 Wage and Tax Statement **2005**

Copy B to be filed with employee's Federal Income Tax Return.

AZ State Reference Copy

W-2 Wage and Tax Statement **2005**

Copy 2 to be filed with employee's State Income Tax Return.

AZ State Filing Copy

W-2 Wage and Tax Statement **2005**

Copy 2 to be filed with employee's State Income Tax Return.

EXHIBIT C PAGE 68

Safe, accurate, FAST! Use e-file Visit the IRS website at www.irs.gov.

Employee Reference Copy

W-2 Wage and Tax Statement 2005

OMB No. 1545-0008

Copy C for employee's records.

a Control number	Dept.	Corp.	Employer use only
100002 49/H&Y	001010	A	9

c Employer's name, address, and ZIP code

SOJOURN CARE, INC
7975 N HAYDEN #A-208
SCOTTSDALE AZ 85258

Batch #01053

e/f Employee's name, address, and ZIP code

[redacted]

b Employer's FED ID number	d Employee's SSA number
01-0651003	[redacted]

1 Wages, tips, other comp.	2 Federal income tax withheld
247971.06	48922.73
3 Social security wages	4 Social security tax withheld
90000.00	5580.00
5 Medicare wages and tips	6 Medicare tax withheld
252971.12	3668.08
7 Social security tips	8 Allocated tips
9 Advance EIC payment	10 Dependent care benefits
11 Nonqualified plans	12a See instructions for box 12 C 100.70
14 Other	12b D 5000.06
	12c
	12d
	13 Stat emp. Ret. plan X 3rd party sick pay

15 State	Employer's state ID no.	16 State wages, tips, etc.
AZ	01-0651003	247971.06
17 State income tax		18 Local wages, tips, etc.
9274.67		
19 Local income tax		20 Locality name

Federal Filing Copy

W-2 Wage and Tax Statement 2005

OMB No. 1545-0008

Copy B to be filed with employee's Federal Income Tax Return.

2005 W-2 and EARNINGS SUMMARY

This blue Earnings Summary section is included with your W-2 to help describe portions in more detail. The reverse side includes general information that you may also find helpful.

1. The following information reflects your final 2005 pay stub plus any adjustments submitted by your employer.

Gross Pay	258274.32	Social Security Tax Withheld Box 4 of W-2	5580.00	AZ. State Income Tax Box 17 of W-2 SUI/SDI Box 14 of W-2	9274.67
Fed. Income Tax Withheld Box 2 of W-2	48922.73	Medicare Tax Withheld Box 6 of W-2	3668.08		

2. Your Gross Pay was adjusted as follows to produce your W-2 Statement.

	Wages, Tips, other Compensation Box 1 of W-2	Social Security Wages Box 3 of W-2	Medicare Wages Box 5 of W-2	AZ. State Wages, Tips, Etc. Box 16 of W-2
Gross Pay	258,274.32	258,274.32	258,274.32	258,274.32
Plus GTL (C-Box 12)	100.70	100.70	100.70	100.70
Less 401(k) (D-Box 12)	5,000.06	N/A	N/A	5,000.06
Less Medical FSA	2,499.90	2,499.90	2,499.90	2,499.90
Less Other Cafe 125	2,904.00	2,904.00	2,904.00	2,904.00
Wages Over Limit	N/A	162,971.12	N/A	N/A
Reported W-2 Wages	**247,971.06**	**90,000.00**	**252,971.12**	**247,971.06**

3. Employee W-4 Profile. To change your Employee W-4 Profile Information, file a new W-4 with your payroll dept.

[redacted]

Social Security Number: [redacted]
Taxable Marital Status:
Exemptions/Allowances:
FEDERAL: 10
STATE: Tax is 19 % of Federal

AZ.State Reference Copy

W-2 Wage and Tax Statement 2005

OMB No. 1545-0008

Copy 2 to be filed with employee's State Income Tax Return.

AZ.State Filing Copy

W-2 Wage and Tax Statement 2005

OMB No. 1545-0008

Copy B to be filed with employee's State Income Tax Return.

EXHIBIT C PAGE 69

Safe, accurate, FAST! Use IRS e-file. Visit the IRS Website at www.irs.gov.

Employee Reference Copy

W-2 Wage and Tax Statement **2005**

OMB No. 1545-0008

Copy C for employee's records

a Control number	Dept.	Corp.	Employer use only
100001 49/H&Y	001010		A 65

c Employer's name, address, and ZIP code

SOJOURN CARE, INC
7975 N HAYDEN #A-208
SCOTTSDALE AZ 85258

Batch #01053

e/f Employee's name, address, and ZIP code

[redacted] 85253

b Employer's FED ID number	d Employee's SSA number
01-0651003	[redacted]

1 Wages, tips, other comp.	2 Federal income tax withheld
245497.23	34901.73
3 Social security wages	4 Social security tax withheld
90000.00	5580.00
5 Medicare wages and tips	6 Medicare tax withheld
250497.29	3632.21
7 Social security tips	8 Allocated tips
9 Advance EIC payment	10 Dependent care benefits
11 Nonqualified plans	12a See instructions for box 12: C 100.70
14 Other	12b D 5000.06
	12c
	12d
	13 Stat emp. X Ret. plan 3rd party sick pay

15 State	Employer's state ID no.	16 State wages, tips, etc.
AZ	01-0651003	245497.23
17 State income tax		18 Local wages, tips, etc.
12880.60		
Local income tax		20 Locality name

2005 W-2 and EARNINGS SUMMARY

This blue Earnings Summary section is included with your W-2 to help describe portions in more detail. The reverse side includes general information that you may also find helpful.

1. The following information reflects your final 2005 pay stub plus any adjustments submitted by your employer.

Gross Pay	254409.95	Social Security Tax Withheld Box 4 of W-2	5580.00	AZ. State Income Tax Box 17 of W-2 SUI/SDI Box 14 of W-2	12880.60
Fed. Income Tax Withheld Box 2 of W-2	34901.73	Medicare Tax Withheld Box 6 of W-2	3632.21		

2. Your Gross Pay was adjusted as follows to produce your W-2 Statement.

	Wages, Tips, other Compensation Box 1 of W-2	Social Security Wages Box 3 of W-2	Medicare Wages Box 5 of W-2	AZ. State Wages, Tips, Etc. Box 16 of W-2
Gross Pay	254,409.95	254,409.95	254,409.95	254,409.95
Plus GTL (C-Box 12)	100.70	100.70	100.70	100.70
Less 401(k) (D-Box 12)	5,000.06	N/A	N/A	5,000.06
Less Medical FSA	399.88	399.88	399.88	399.88
Less Other Cafe 125	3,613.48	3,613.48	3,613.48	3,613.48
Wages Over Limit	N/A	160,497.29	N/A	N/A
Reported W-2 Wages	**245,497.23**	**90,000.00**	**250,497.29**	**245,497.23**

3. Employee W-4 Profile. To change your Employee W-4 Profile information, file a new W-4 with your payroll dept.

[redacted]

Social Security Number: [redacted]
Taxable Marital Status:
Exemptions/Allowances:
FEDERAL: 24
STATE: Tax is 37 % of Federal

Federal Filing Copy

W-2 Wage and Tax Statement **2005**

OMB No. 1545-0008

Copy B to be filed with employee's Federal Income Tax Return.

AZ State Reference Copy

W-2 Wage and Tax Statement **2005**

OMB No. 1545-0008

Copy 2 to be filed with employee's State Income Tax Return.

AZ State Filing Copy

W-2 Wage and Tax Statement **2005**

OMB No. 1545-0008

Copy 2 to be filed with employee's State Income Tax Return.

EXHIBIT C PAGE 70

Attachment for Section C, Question 3

Sojourn Care (Leasee) and Valley Ridge Partners, L.P (Formerly KWIRP-Tulsa Associates, L.P. (Lessor)
Amendment #1 May 2, 2005 to leased date April 29, 2004
Beginning Date: 8/1/2005
Ending Date: 10/31/2011
Amended for addition of additional office space.
Annual charge of Lessor = $142,223

Sojourn Care (Lessee) and Drumright Industrial Authority (Lessor)
Beginning Date: 7/1/2005
Ending Date: 6/30/2010
Satalite office space
Annual Charge of Lessor = $6,000

Sojourn Care
2006

Date	Proposal	Invoice	Amount
1/18/2005	11221C	11183	3,057.26
9/30/2005	15187	13308	203,486.42
10/27/2005	15358	13488	3,715.78
11/30/2005	15187A	13884	3,685.93
12/30/2005	15187B	14116	1,749.59
8/19/2005	Deposit		(68,795.00)
4/11/2006	Payment		(70,000.00)
	Outstanding Balance		76,899.98
	Amount to be financed (See Payment Schedule)		$76,899.98

EXHIBIT C PAGE 72

2005 COST Report Supporting Documents

EXHIBIT C PAGE 73

Sojourn Care, Inc.
Calculation of Direct Patient Care Hours

Average Miles per Hour 45

Quarter 1

	80% HOURS	TRAVEL TIME	Direct Pcare Hours
Chaplain	1,828	375	1,453
HHA	11,786	2,759	9,027
Nurse	10,456	2,102	8,354
SocialWorker	3,019	341	2,678
Grand Total	27,089	5,577	21,513
Volunteer Hours			2,515
% of patient care			**11.7%**

Quarter 2

	80% HOURS	TRAVEL TIME	Direct Pcare Hours
Chaplain	2,611	489	2,122
HHA	13,293	3,451	9,842
Nurse	13,225	2,733	10,491
SocialWorker	2,962	390	2,572
Grand Total	32,091	7,063	25,028
Volunteer Hours			1,776
% of patient care			**7.1%**

Quarter 3

	80% HOURS	TRAVEL TIME	Direct Pcare Hours
Chaplain	2,920	705	2,215
HHA	15,657	3,851	11,806
Nurse	15,504	3,120	12,384
SocialWorker	3,783	525	3,258
Grand Total	37,864	8,202	29,663
Volunteer Hours			1,317
% of patient care			**4.4%**

Quarter 4

	80% HOURS	TRAVEL TIME	Direct Pcare Hours
Chaplain	3,282	981	2,301
HHA	19,238	4,272	14,967
Nurse	16,562	3,631	12,932
SocialWorker	4,479	680	3,799
Grand Total	43,562	9,564	33,998
Volunteer Hours			993
% of patient care			**2.9%**

Total Year 2005

	80% HOURS	TRAVEL TIME	Direct Pcare Hours
Chaplain	10,642	2,551	8,091
HHA	59,974	14,333	45,642
Nurse	55,747	11,586	44,161
SocialWorker	14,244	1,936	12,308
Grand Total	140,607	30,405	110,202
Volunteer Hours			6,601
% of patient care			**6.0%**

Volunteer Hours Reported

Month	Vol Hours
1/31/2005	881
2/28/2005	863
3/31/2005	772
	2,515
4/30/2005	605
5/31/2005	721
6/30/2005	450
	1,776
7/31/2005	447
8/31/2005	480
9/30/2005	390
	1,317
10/31/2005	363
11/30/2005	289
12/31/2005	341
	993
Total	6,601

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
DME Regional Carrier

Facsimile Cover Sheet

To: Rene Berryman
Provider Name:
Phone:
Fax: 480-905-1352
From: Deanna Morris
Company: Palmetto GBA
Phone: (727) 773-9225 Extension 15612
Fax: (727 771-7838
Date: 02/27/2006
Pages including cover:

Confidentiality Statement

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Comments: PS&R provider #37-1607

Palmetto GBA
Provider Reimbursement
34850 US Highway 19 North, Suite 202 • Palm Harbor, Florida • 34684-2158 • (727) 773-9225 • Fax (727) 771-7838
A CMS Contracted Intermediary and Carrier

EXHIBIT C PAGE 15

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

PAGE: 19009
REPORT #: OD44203
REPORT TYPE: 01A

PROVIDER ID: MD430502 - V35.C
DATES: 01/01/93 THRU 02/16/06
RUN DATE: 02/16/06
PROVIDER FYE: 12/31
PROVIDER NUMBER: 371607

PROVIDER SUMMARY REPORT
HOSPICE - NON-HOSPITAL BASED (MSP-LCC)

Sojourn Care of Tulsa

REVENUE CODE	DESCRIPTION	SERVICES FOR PERIOD 01/01/04 - 12/31/04 UNITS	CHARGES	SERVICES FOR PERIOD 01/01/05 - 12/31/05 UNITS	CHARGES	SERVICES FOR PERIOD 01/01/06 - 12/31/06 UNITS	CHARGES	SERVICES FOR PERIOD 01/01/07 - 12/31/07 UNITS	CHARGES
	DISCHARGES	0		0		0		0	
	MEDICARE DAYS	0		0		0		0	
	CLAIMS	0		2		0		0	
	*** ANCILLARY CHARGES ***								
0651	HOSPICE/RTN HOME		$.00	24	$4,320.00		$.00		$.00
	TOTAL CHARGES		$.00		$4,320.00		$.00		$.00
	GROSS REIMBURSEMENT		$.00		$2,400.00		$.00		$.00
	CASH DEDUCTIBLE		$.00		$.00		$.00		$.00
	BLOOD DEDUCTIBLE		$.00		$.00		$.00		$.00
	COINSURANCE		$.00		$.00		$.00		$.00
	NET PRIMARY PAYOR PAYMENTS MADE UNDER MSP		$.00		$2,087.28		$.00		$.00
	NET REIMBURSEMENT		$.00		$312.72		$.00		$.00
	INFORMATIONAL ONLY:								
	INTEREST PAYMENTS		$.00		$.00		$.00		$.00
	TOB ADJUSTMENTS		$.00		$.00		$.00		$.00

EXHIBIT C PAGE 76

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

PAGE: 19010
REPORT #: 0D44203
REPORT TYPE: 810

PRO ID: MD430502 - V35.C
PAI ED: 01/01/93 THRU 02/16/06
RUN DATE: 02/16/06
PROVIDER FYE: 12/31
PROVIDER NUMBER: 371607

PROVIDER SUMMARY REPORT
HOSPICE - NON-HOSPITAL BASED

Sojourn Care of Tulsa

REVENUE CODE	DESCRIPTION	SERVICES FOR PERIOD 01/01/04 - 12/31/04 UNITS	SERVICES FOR PERIOD 01/01/04 - 12/31/04 CHARGES	SERVICES FOR PERIOD 01/01/05 - 12/31/05 UNITS	SERVICES FOR PERIOD 01/01/05 - 12/31/05 CHARGES	SERVICES FOR PERIOD 01/01/06 - 12/31/06 UNITS	SERVICES FOR PERIOD 01/01/06 - 12/31/06 CHARGES	SERVICES FOR PERIOD 01/01/07 - 12/31/07 UNITS	SERVICES FOR PERIOD 01/01/07 - 12/31/07 CHARGES
	DISCHARGES	0		0		0		0	
	MEDICARE DAYS	27,501		0		0		0	
	CLAIMS	4,677		8,670		697			
	*** ANCILLARY CHARGES ***								$.00
0651	HOSPICE/RTN HOME	62,592	$7,006,429.16	111,630	$13,293,929.15	7,034	$932,880.71		$.00
0652	HOSPICE/CTNS HOME	2,445	$65,435.24	855	$24,717.65		$.00		$.00
0655	HOSPICE/IP RESPITE	124	$14,555.86	208	$25,905.26	13	$6,958.12		$.00
0656	HOSPICE/IP NON RESP	380	$189,618.05	371	$198,595.96		$.00		$.00
0657	HOSPICE/PHYSICIAN S	255	$23,770.22	296	$43,718.00		$939,838.83		$.00
	TOTAL CHARGES		$7,299,750.53		$13,586,071.02				
	GROSS REIMBURSEMENT		$7,292,201.78		$13,565,327.83		$939,818.53		$.00
	CASH DEDUCTIBLE		$.00		$.00		$.00		$.00
	BLOOD DEDUCTIBLE		$.00		$.00		$.00		$.00
	COINSURANCE		$.00		$.00		$.00		$.00
	NET PRIMARY PAYOR PAYMENTS MADE UNDER MSP		$977.60		$3,100.00		$.00		$.00
	NET REIMBURSEMENT		$7,291,224.18		$13,562,227.83		$939,818.53		$.00
	INFORMATIONAL ONLY:								
	INTEREST PAYMENTS		$.00		$97.16		$.00		$.00
	TOTAL ADJUSTMENTS		$.00		$.00		$.00		$.00

EXHIBIT L PAGE 77

PROGRAM ID: MD4300S06 - V36.C
PAT[illegible]ATES: 01/01/93 THRU 02/16/06
RE TE: 02/16/06
PR ER FYE: 1231
PROVIDER: 371607 Sojourn Care of Tulsa

PROVIDER SUMMARY REPORT
MSA/BENEFICIARY CENSUS/REV VISITS
HOSPICE - NON-HOSPITAL BASED (MSP-LCC)

PAGE: 13915
REPORT #: OD45300
REPORT TYPE: 81A

COUNT TYPE	SERVICE PERIOD 01/01/04-12/31/04	SERVICE PERIOD 01/01/05-12/31/05	SERVICE PERIOD 01/01/06-12/31/06	SERVICE PERIOD 01/01/07-12/31/07
ALL CBSA BENEFICIARY COUNTS	0.00	1.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	24	0	0
8960 BENEFICIARY COUNTS	0.00	1.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	24	0	0

EXHIBIT L PAGE 78

PROGRAM ID: MD430506 - V35.C
PAI TES: 01/01/93 THRU 02/16/06
RUN A: 02/16/06
PROVIDER FYE: 1231
PROVIDER: 371667 Sojourn Care of Tulsa

PROVIDER SUMMARY REPORT
MSA/BENEFICIARY CENSUS/REV VISITS
HOSPICE - NON-HOSPITAL BASED

REPORT #: OD45J00
REPORT TYPE: R10

COUNT TYPE	SERVICE PERIOD 01/01/04-12/31/04	SERVICE PERIOD 01/01/05-12/31/05	SERVICE PERIOD 01/01/06-12/31/06	SERVICE PERIOD 01/01/07-12/31/07
ALL CBSA BENEFICIARY COUNTS	501.00	827.00	341.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	62592	111830	7834	0
REVENUE CNTR 0652 VISIT COUNTS	2445	855	0	0
BCSA 37 BENEFICIARY COUNTS	35.80	57.34	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	3406	7678	0	0
REVENUE CNTR 0652 VISIT COUNTS	225	68	0	0
BCSA 0104 BENEFICIARY COUNTS	0.00	7.50	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	953	0	0
BCSA 0341 BENEFICIARY COUNTS	0.00	117.63	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	18074	0	0
BCSA 50104 BENEFICIARY COUNTS	0.00	7.55	14.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	633	309	0
REVENUE CNTR 0652 VISIT COUNTS	0	12	0	0
BCSA 50106 BENEFICIARY COUNTS	0.00	0.01	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	3	0	0
BCSA 50107 BENEFICIARY COUNTS	0.00	19.37	22.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	2123	561	0
BCSA 50304 BENEFICIARY COUNTS	0.00	0.00	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	0	0	0
BCSA 50341 BENEFICIARY COUNTS	0.00	130.12	305.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	0	11347	6964	0
REVENUE CNTR 0652 VISIT COUNTS	0	54	0	0
BCSA 8560 BENEFICIARY COUNTS	465.20	487.70	0.00	0.00
REVENUE CNTR 0651 VISIT COUNTS	59106	71019	0	0
REVENUE CNTR 0652 VISIT COUNTS	2220	721	0	0

EXHIBIT L PAGE 79

Revenue and Expense Analysis for the Period from 01-01-2005 to 12-31-2005

Pay Source Medicare Benefit

Mode: All Patients

Part 1: Revenue

Service/Level of Care	Visits/Days	Tot Dir Hours	Gross	Net	Discount
Benefit Mode					
General Inpatient Care	377	.00	201,807.48	201,807.48	.00
Routine Home Care	112,910	.00	13,418,977.88	13,414,794.48	4,183.40
Inpatient Respite Care	209	.00	26,095.15	26,095.15	.00
Continuous Home Care	46	903.00	26,118.92	26,118.92	.00
Subtotal Benefit Mode	**113,542**	**903.00**	**13,672,999.43**	**13,668,816.03**	**4,183.40**
Total Revenue	**113,542**	**903.00**	**13,672,999.43**	**13,668,816.03**	**4,183.40**

No. Patients: 859 **Active Days:** 113,553 **Revenue per Active Day:** 120.37

Part 2: Direct Expenses

Type of Service	Visits	Direct	Indirect	Travel	Total Time	Cost
Staff Services						
Administrative - Hourly (staff)	0	5.00	.00	.00	5.00	.00
Home Health Aide (staff)	32	133.19	.00	.00	133.19	.00
Hospice RN (staff)	30	79.25	.00	.00	79.25	.00
Licensed Practical Nurse (staff)	33	147.44	.00	.00	147.44	.00
Nurse Supervisor (staff)	2	4.00	.00	.00	4.00	.00
Subtotal Staff Services	**97**	**368.88**	**.00**	**.00**	**368.88**	**.00**
Contractor Services						
Contract Home Health Aide	8	49.50	.00	.00	49.50	.00
Contract LPN	64	486.09	.00	.00	486.09	.00
Contract RN	4	41.00	.00	.00	41.00	.00
Subtotal Contractor Services	**76**	**576.59**	**.00**	**.00**	**576.59**	**.00**
Total Expenses	**173**	**945.47**	**.00**	**.00**	**945.47**	**.00**

No. Patients: 39 **Active Days:** 78 **Cost per Active Day:** .00

EXHIBIT C PAGE 80

Revenue and Expense Analysis for the period from 01-01-2005 to 12-31-2005

Pay Source Medicare Benefit

Pre-admission/Post-discharge Services

Part 2: Direct Expenses

Type of Service	Visits	Direct	Indirect	Travel	Total Time	Cost
Staff Services						
Administrative (staff)	0	2.00	.00	.00	2.00	.00
Administrative - Hourly (staff)	0	4.00	.00	.00	4.00	.00
Subtotal Staff Services	**0**	**6.00**	**.00**	**.00**	**6.00**	**.00**
Total Expenses	**0**	**6.00**	**.00**	**.00**	**6.00**	**.00**

No. Patients: 12 **Active Days:** 12 **Cost per Active Day:** .00

EXHIBIT C PAGE 81

Revenue and Expense Analysis for the period from 01-01-2005 to 12-31-2005

Pay Source Medicare Benefit

Summary for all Patients

Part 1: Revenue

Service/Level of Care	Visits/Days	Tot Dir Hours	Gross	Net	Discount
Benefit Mode					
General Inpatient Care	377	.00	201,807.48	201,807.48	.00
Routine Home Care	112,910	.00	13,418,977.88	13,414,794.48	4,183.40
Inpatient Respite Care	209	.00	26,095.15	26,095.15	.00
Continuous Home Care	46	903.00	26,118.92	26,118.92	.00
Subtotal Benefit Mode	**113,542**	**903.00**	**13,672,999.43**	**13,668,816.03**	**4,183.40**
Total Revenue	**113,542**	**903.00**	**13,672,999.43**	**13,668,816.03**	**4,183.40**

Part 2: Direct Expenses

Type of Service	Visits	Direct	Indirect	Travel	Total Time	Cost
Staff Services						
Administrative (staff)	0	2.00	.00	.00	2.00	.00
Administrative - Hourly (staff)	0	9.00	.00	.00	9.00	.00
Home Health Aide (staff)	32	133.19	.00	.00	133.19	.00
Hospice RN (staff)	30	79.25	.00	.00	79.25	.00
Licensed Practical Nurse (staff)	33	147.44	.00	.00	147.44	.00
Nurse Supervisor (staff)	2	4.00	.00	.00	4.00	.00
Subtotal Staff Services	**97**	**374.88**	**.00**	**.00**	**374.88**	**.00**
Contractor Services						
Contract Home Health Aide	8	49.50	.00	.00	49.50	.00
Contract LPN	64	486.09	.00	.00	486.09	.00
Contract RN	4	41.00	.00	.00	41.00	.00
Subtotal Contractor Services	**76**	**576.59**	**.00**	**.00**	**576.59**	**.00**
Total Expenses	**173**	**951.47**	**.00**	**.00**	**951.47**	**.00**

EXHIBIT C PAGE 82

Revenue and Expense Analysis for the period from 01-01-2005 to 12-31-2005
Report Specification Summary

Date range	
Begin Date	01-01-2005
End Date	12-31-2005
Mode	
All Patients	Y
Multiple Dataset Consolidation	N
Optional Selection Criteria	
Patient Class	None
Pay Source	Medicare Benefit
Team	None
Branch	None
Diagnosis Group	None
Acuity Level	None
Company	None
Facility	None
Options	
Start Date for YTD Totals	None
Include Pending Pay Source	Y

Note: When run for the same periods in any other mode the totals are based on date provided and will change when adding changes to prior periods. Totals on this report will not match Billing Register or the Accounts Receivable Report.

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